Regence BlueCross BlueShield of Oregon Policy

Individual Group Number: 37000201

2023 Medical Benefits

Regence

Notice: Your Rights and Protections Against Surprise Medical Bills

When You get emergency care or are treated by an out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, You are protected from balance billing. In these cases, You shouldn't be charged more than Your plan's Copayments, Coinsurance and/or Deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When You see a doctor or other health care Provider, You may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if You see a Provider or visit a health care facility that isn't in Your health plan's network.

"Out-of-network" as used in this Notice, means Providers and facilities that haven't signed a contract with Your health plan to provide services. Out-of-network Providers may be allowed to bill You for the difference between what Your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward Your plan's Deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when You can't control who is involved in Your care - like when You have an emergency or when You schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If You have an Emergency Medical Condition and get emergency services from an out-of-network Provider or facility, the most they can bill You is Your plan's in-network cost-sharing amount (such as Copayments, Coinsurance, and Deductibles). You **can't** be balance billed for these emergency services. This includes services You may get after You're in stable condition, unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network Hospital or Ambulatory Surgical Center

When You get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those Providers may bill You is Your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill You and may **not** ask You to give up Your protections not to be balance billed.

If You get other types of services at these in-network facilities, out-of-network Providers **can't** balance bill You, unless You give written consent and give up Your protections.

You're <u>never</u> required to give up Your protections from balance billing. You also aren't required to get care out-of-network. You can choose a Provider or facility in Your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You are only responsible for paying Your share of the cost (like the Copayments, Coinsurance, and Deductibles that You would pay if the Provider or facility was in-network). Your health plan will pay any additional costs to out-of-network Providers and facilities directly.
- Generally, Your health plan must:
    - Cover emergency services without requiring You to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network Providers.
    - Base what You owe the Provider or facility (cost-sharing) on what it would pay an in-network Provider or facility and show that amount in Your explanation of benefits.
    - Count any amount You pay for emergency services or out-of-network services toward Your in-network Deductible and out-of-pocket limit.

If You believe You've been wrongly billed by Us, contact the Oregon Division of Financial Regulation by:

- calling the Consumer Hotline at 1 (888) 877-4894;
- e-mail at: **DFR.InsuranceHelp@dcbs.oregon.gov**; or
- filing a complaint at: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**.

If You believe You've been wrongly billed by a Provider, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1 (800) 985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about Your rights under federal law.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Introduction

Regence BlueCross BlueShield of Oregon

Street Address:
100 SW Market Street
Portland, OR 97201

Medical/Pediatric Dental Claims Address:
P.O. Box 1106
Lewiston, ID 83501-1106

Pediatric Vision Claims Address:
Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Medical/Pediatric Dental Customer Service/Correspondence Address:
P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Pediatric Vision Customer Service/Correspondence Address:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Medical/Pediatric Dental Appeals Address:
Attn: Member Appeals
P.O. Box 1408
Lewiston, ID 83501

Pediatric Vision Appeals Address:
Attn: Complaint and Grievance Unit
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

In this Policy, the terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Oregon. References to "You" and "Your" refer to both the Policyholder and Enrolled Dependents. "Policyholder" means a person who is enrolled for coverage under a Regence BlueCross BlueShield of Oregon health insurance Policy, and whose name appears on the records of Regence BlueCross BlueShield of Oregon as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

POLICY

This Policy is a Health Benefit Plan for individuals and their families. This Policy describes benefits effective **December 1, 2023**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage. This Policy, including Your application, endorsements and attached papers constitutes the entire contract. This Policy replaces any policy, plan description or certificate previously issued by Us and makes it void. The "identification card" issued to You includes Your name and Your identification number for this

coverage. Present Your identification card to Your Provider before receiving care.

Regence BlueCross BlueShield of Oregon, an independent licensee of the Blue Cross and Blue Shield Association, agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

EXAMINATION OF POLICY
If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the above-named Policyholder will be entitled to return this Policy within 10 days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated 10-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. (If benefits already paid under this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums.)

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This coverage complies with the Mental Health Parity and Addiction Equity Act of 2008.

ESSENTIAL HEALTH BENEFITS
This coverage complies with the essential health benefits in the following ten categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services (including chronic disease management); and
- pediatric services (including oral and vision care).

RISK-SHARING ARRANGEMENTS WITH PROVIDERS
This plan includes "Risk-Sharing Arrangements" with Providers who provide services to the Insureds of this plan. Under a Risk-Sharing Arrangement, the Providers that are responsible for delivering health care services are subject to some financial risk or reward for the services they deliver. Periodically, We may make payments to, or receive payments or refunds from, In-Network Providers under Risk-Sharing Arrangements We have with them. Those payments do not affect Your Deductible, Copayment or Coinsurance (which is calculated from the billed charges or Allowed Amount), if any, and consequently also do not affect Your Out-of-Pocket Maximums.

See the definitions of Allowed Amount and Risk-Sharing Arrangement in the Definitions Section. Additional information on Our Risk-Sharing Arrangements is available upon request by calling Customer Service at the number listed below.

NOTICE OF PRIVACY PRACTICES
Regence BlueCross BlueShield of Oregon has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION
Customer Service: 1 (888) 675-6570
(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- via Our Web site, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via Our Web site); or
- for assistance in a language other than English.

Pediatric Vision Services – Vision Service Plan (VSP): 1 (844) 299-3041
(hearing impaired: 1 (800) 428-4833)

VSP phone lines are open Monday – Friday 5 a.m. – 8 p.m., Saturday 7 a.m. – 8 p.m. and Sunday 7 a.m. – 7 p.m.

Contact VSP if You have Provider or benefit questions specific to Your pediatric vision coverage. You may also visit VSP's Web site at **www.vsp.com**.

Case Management: Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information, refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

BlueCard® Program: This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueCross BlueShield of Oregon serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

Lindsay Harris
President
Regence BlueCross BlueShield of Oregon

Renee Balsiger
Vice President, Sales
Regence BlueCross BlueShield of Oregon

Using Your Regence Bronze Essential 8000 With 4 Copay No Deductible Office Visits Legacy LHP Policy

EXCLUSIVE PROVIDERS

Except for those Covered Services (Urgent Care, Ambulance Services, Blood Bank and Emergency Room and, in some circumstances, Oregon Out-of-Network Provider care at an In-Network healthcare facility) specified for Out-of-Network Providers in the Medical Benefits Section, Your plan requires that You receive Covered Services from In-Network Providers. See also "Services Received From An Oregon Out-of-Network Provider In An In-Network Healthcare Facility" provision for those circumstances in which Out-of-Network services may be covered.

For services under the Gene Therapy and Adoptive Cellular Therapy benefit to be covered, services must be received at a Center of Excellence identified by Us for the particular therapy.

To receive care at the lowest amount of out-of-pocket expense, You must receive Covered Services from a Provider in Your network (In-Network). Receiving Covered Services from a Provider in Your network means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance.

Go to **regence.com** for further Provider network information for Your medical benefits. Also, refer to the Out-of-Area Services provision under the Policy and Claims Administration Section for coverage through the BlueCard Program when traveling outside Our service area.

SERVICES RECEIVED FROM AN OREGON OUT-OF-NETWORK PROVIDER IN AN IN-NETWORK HEALTHCARE FACILITY

Regardless of any provision to the contrary, if You receive services from an Oregon licensed or certified Out-of-Network Provider at an In-Network Hospital, Ambulatory Surgical Center, freestanding birthing center, or outpatient renal dialysis center, You may not be responsible for their charges in excess of any In-Network cost-share for:

- emergency services; or
- other inpatient or outpatient services, unless the Out-of-Network Provider obtained Your informed consent in advance of the services in a manner established by the state.

This does not apply to:

- a residential facility licensed by the Department of Human Services or the Oregon Health Authority under Oregon law;
- an establishment furnishing primarily domiciliary care as described under Oregon law;
- a residential facility licensed or approved under the rules of the Department of Corrections;
- facilities established through the Oregon Health Authority for the treatment of substance abuse disorders;

- community mental health programs or community developmental disabilities programs established under Oregon law; or
- a long-term care facility.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to Our Web site and Our mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR POLICY.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of this Policy.

- **Go to regence.com or Our mobile application.** You can use these secure applications to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider or identify Participating Pharmacies;
  - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
  - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
  - learn about prescriptions for various Illnesses;
  - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
  - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. We have contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.* Regence Advantages is available to You at no additional cost. The discounts vary depending on the product, service or program partner. The discount savings are either a flat dollar amount or a percentage ranging from 5% to 60% off of a product or service. Program partners may have limitations or exclusions on their products or services. To find information about any limitations or exclusions, visit the program partner's Web site or contact them directly. You can contact Customer Service if You don't have access to the Internet.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by Your Policy, that also may create savings or administrative fees for Us. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the benefit sections to see what Your benefits are.

Note: If You are a Native American enrolled on this plan and receive services directly from the Indian Health Service, and Indian Tribe, Tribal Organizations, or Urban Indian Organization, or through referral under the Policy health services, the services will not be subject to any Deductible, Copayments, or Coinsurance. Also, if You are classified as an "Indian" under federal law, You may move between qualified health plans one time per month.

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the benefit sections to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this Policy, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount.

The Family Deductible is satisfied when any combination of Family members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.

We do not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Deductible. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon does not apply toward the Deductible.

COPAYMENTS
Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

COINSURANCE (PERCENTAGE YOU PAY)
Your Coinsurance is the percentage You pay when Our payment is less than 100 percent. The Coinsurance varies depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied the Deductible and/or any applicable Copayment for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. We do not reimburse Providers for charges above the Allowed Amount.

OUT-OF-POCKET MAXIMUM
The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is an individual Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount.

The Family Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost-shares for Covered Services total the Family Out-of-Pocket Maximum. No one Family member may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year. A Family member does not have to satisfy their individual Out-of-Pocket Maximum if the Family Out-of-Pocket Maximum has already been satisfied.

Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon does not apply toward the Out-of-Pocket Maximum when purchased through Our Specialty Pharmacy. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. Refer to the benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW
The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year.

Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage. All benefits are listed alphabetically, with the exception of Upfront Benefits, Preventive Care and Immunizations and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this plan. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit Our Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through Our Web site, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PRIOR AUTHORIZATION

Prior authorization refers to the process by which We determine that a proposed service or supply is Medically Necessary and provide approval for it before it is rendered.

Prior authorization is performed to ensure that the medical services You receive are aligned with evidence-based criteria and to determine whether the requested service meets Our Medical Necessity criteria. Prior authorization also ensures that services or supplies You receive are safe, effective and appropriate.

Contracted Providers
Contracted Providers may be required to obtain prior authorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered in this Policy.

Non-Contracted Providers
Non-contracted Providers are not required to obtain prior authorization from Us in advance for Covered Services. You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in this Policy. You may request that a non-contracted Provider prior authorize outpatient services on Your behalf to determine Medical Necessity prior to the service being rendered.

Services Requiring Prior Authorization
A comprehensive list of services and supplies that must be prior authorized may be obtained by visiting Our Web site or contacting Customer Service. Prior authorization requests should be submitted by Your Provider following the instructions on Our Web site.

We will not require prior authorization for Emergency Room services or other services and supplies which by law do not require prior authorization.

Time Frame for Response
You will be notified in writing within two business days after We receive the prior authorization request to let You know whether the request has been approved, denied, or if more information is needed to make a determination. When more information is needed to make a determination, We will notify You in writing of the determination within two business days after We receive the additional information or within 15 calendar days of the original two business days if no additional information is received.

If We do prior authorize a service or supply (from a contracted or non-contracted Provider), We are bound to cover it as follows:

- If Your coverage terminates within five business days of the prior authorization date, We will cover the prior authorized service or supply if the service or supply is actually incurred within those five business days, regardless of the termination date, unless We are aware the coverage is about to terminate and We disclose this information in Our written prior authorization. In that case, We will only cover the prior authorized service or supply if incurred before termination.
- If Your coverage terminates later than five business days after the prior authorization date, but before the end of 30 calendar days, We will not cover services incurred after termination even if the services were prior authorized.
- If coverage remains in effect for at least 30 calendar days after the prior authorization, We will cover the prior authorized service or supply if incurred within the 30 calendar days.

When counting the days described above, day one will begin on the calendar or business day after We prior authorize the service or supply.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES
Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Policy will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES
Per Insured: $8,000
Per Family: $16,000

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
Per Insured: $9,100
Per Family: $18,200

UPFRONT BENEFITS
Upfront Benefits for office or urgent care visits for treatment of Illness or Injury are covered when provided by a Primary Physician, Practitioner or Specialist. For Upfront Benefits, You are not responsible for any Coinsurance. You can track Your benefits by accessing Our Web site or by contacting Customer Service.

Upfront Benefits for Office or Urgent Care Visits

	Provider: In-Network	**Provider: Out-of-Network**
Office Visits	**Payment:** You pay $60 Copayment per visit.	**Payment:** Not covered.
Urgent Care	**Payment:** You pay $60 Copayment per visit.	**Payment:** You pay $60 Copayment per visit and the balance of billed charges.
Limit: four visits, combined, per Insured per Calendar Year. Once this limit is reached, office visits are covered under the applicable benefit for such service. NOTE: Virtual care services are covered in the Virtual Care benefit and do not accrue to this limit.		

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.

PREVENTIVE CARE AND IMMUNIZATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings (including screening and counseling for some cancer genes such as BRCA1 or BRCA2);
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- routine colonoscopies and colorectal cancer examinations, including for those Insureds at high-risk or follow-up colonoscopies performed as a result of a positive non-invasive stool-based screening test or direct visualization screening test. Colonoscopy services include all associated services such as double contrast barium enemas, anesthesia and pathology. Colonoscopy supplies such as bowel prep kits on Our Drug List are covered in the Prescription Medications Section with a Prescription Order;
- breast pump (including its accompanying supplies) per pregnancy as follows:
  - one new non-Hospital grade breast pump when obtained from an In-Network Provider (including a Durable Medical Equipment supplier); or
  - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods, including, but not limited to:
  - condoms;
  - diaphragm with spermicide;
  - sponge with spermicide;
  - cervical cap with spermicide;
  - spermicide;
  - oral contraceptives (combined pill, mini pill, and extended/continuous use pill);
  - contraceptive patch;
  - vaginal ring;
  - contraceptive shot/injection;

- emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products);
- intrauterine devices (both copper and those with progestin);
- implantable contraceptive rod;
- surgical implants; and
- surgical sterilization.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective in this Policy.

For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit Our Web site or contact Customer Service. You can also visit the HRSA Web site at: **http://www.hrsa.gov/womensguidelines/** for women's preventive services guidelines, and the USPSTF Web site at: **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a list of A and B preventive services.

Expanded Immunizations

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Unless otherwise covered in the Upfront Benefits, services and supplies provided by a professional Provider are covered subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly, foot care associated with diabetes and Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished

sensation in the legs or feet.

Dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function are also covered. A "craniofacial anomaly" is a physical disorder, identifiable at birth, that affects the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage does not include treatment of temporomandibular joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Additionally, coverage includes some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our Web site or contact Customer Service.

Breast, Pelvic and Pap Smear Examinations
Breast, pelvic and Pap smear examinations not covered in the Preventive Care and Immunizations benefit.

Diabetes Management Associated with Pregnancy
Management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum (for each pregnancy) that is Medically Necessary and a Covered Service is not subject to any Deductible, Copayment and/or Coinsurance.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress test, sleep studies and neurology/neuromuscular procedures.

Medical Colonoscopy
Diagnostic medical colonoscopies not covered in the Preventive Care and Immunizations benefit.

Office or Urgent Care Visits – After Upfront Benefit Limits
After any Upfront office visit limits are exhausted, office or urgent care visits for treatment of Illness or Injury are covered. Urgent care visits will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance.

Professional Inpatient
Professional inpatient visits for treatment of Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, We will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer

Service for further information and guidance.

Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury, including, but not limited to:

- genetic testing, when performed for a medical reason or for a condition that requires genetic testing, provided the results of the testing have the potential to improve Health Outcomes;
- diagnostic mammography services not covered in the Preventive Care and Immunizations benefit; and
- HIV testing.

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

Surgical Services
Surgical services and supplies including cochlear implants (programming and reprogramming, cost of repair and replacement parts if the repair or parts are not covered by a warranty and are Medically Necessary for the device to be functional) for the treatment of hearing loss and the services of a surgeon, an assistant surgeon and an anesthesiologist.

Treatment of varicose veins is only covered when there is:

- active associated venous ulceration;
- objective documentation of persistent or recurrent bleeding from ruptured veins; or
- objective documentation of recurrent superficial phlebitis.

Therapeutic Injections
Therapeutic injections and related supplies, including clotting factor products, when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered in the Prescription Medications Section.

ACUPUNCTURE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: 12 visits per Insured per Calendar Year	

Acupuncture is covered. Acupuncture visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, You pay 10% of the Allowed Amount.

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the

transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers. We will send Our payment for Covered Services directly to the ambulance service Provider.

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits and Prescription Medications Sections. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a clinical trial that is a study or investigation:

- approved or funded by one or more of:
  - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - the VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Routine Patient Costs means items and services that typically are Covered Services for an Insured not enrolled in a clinical trial, but do not include:

- an Investigational item, device, or service that is the subject of the Approved Clinical Trial unless it would be covered for that indication absent a clinical trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Insured; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BIOFEEDBACK

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: ten visits for migraine headaches or urinary incontinence combined per Insured Lifetime	

Biofeedback to treat migraine headaches or urinary incontinence is covered. We do not cover biofeedback for other conditions. Biofeedback visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

BLOOD BANK

Provider: All
Payment: After Deductible, You pay 10% of the Allowed Amount.

Services and supplies of a blood bank are covered, excluding storage costs.

CARDIAC REHABILITATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Inpatient limit: unlimited **Outpatient limit:** 36 visits per Insured Lifetime	

Medically Necessary phase I (inpatient) and phase II (short-term outpatient) cardiac rehabilitation services associated with a cardiac rehabilitation exercise program are covered. We do not cover phase III (long-term outpatient) services. Outpatient cardiac rehabilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

CHILD ABUSE MEDICAL ASSESSMENT

Child Abuse Medical Assessments including those services provided by an Oregon Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan are covered as specified in the Medical Benefits Section. The services include, but are not limited to, a forensic interview and Mental Health treatment.

Definitions

The following definitions apply to this Child Abuse Medical Assessment benefit:

Child Abuse Medical Assessment means an assessment by or under the direction of a licensed Physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. Child Abuse Medical Assessment includes the taking of a thorough medical history, a complete physical examination and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the

child.

Community Assessment Center means a neutral, child-sensitive community-based facility or service Provider to which a child from the community may be referred to receive a thorough Child Abuse Medical Assessment for the purpose of determining whether the child has been abused or neglected.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Medically Necessary detoxification is covered.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Services and supplies for inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: one pair of glasses (frames and lenses) or contact lenses per Insured per Calendar Year to correct visual defect due to severe medical or surgical problem such as stroke, neurological disease, trauma or eye surgery other than refractive procedures **Limit:** one synthetic wig per Insured per Calendar Year. For reimbursement, You submit a Prescription Order from Your Provider and an itemized purchase receipt indicating the type of wig and the charges. You are reimbursed at the In-Network benefit level.	

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wigs, glasses or contact lenses, wheelchairs and supplies or equipment associated with diabetes. Wigs, glasses or contact lenses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our Web site or contact Customer Service.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and the balance of billed charges.

Emergency room services and supplies are covered, including outpatient charges for patient observation and medical screening examinations that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be prior authorized.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Insured from a facility; and
- in the case of a covered Insured, who is pregnant, to perform the delivery (including

the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Insureds who fulfill the Medical Necessity criteria.

To be covered at the Centers of Excellence (COE) benefit level, gene therapy and/or adoptive cellular therapy must be received from one of Our COE facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from an In-Network Provider to be covered at the COE benefit level. For a list of covered therapies or to identify a COE facility, contact Our Customer Service as the lists are subject to change.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
Limit: $7,500 per Insured per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Insured and one companion (or two companions if the Insured is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Insured, not to exceed $100 per night for the Insured and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
  - commercial coach class airfare;
  - commercial coach class train fare; or

- documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of treatment. We will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Our Customer Service for further information and guidance.

Coverage does not include meals or expenses outside of transportation and lodging.

HABILITATIVE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Inpatient limit: 30 days per Insured per Calendar Year (up to 60 days per Calendar Year for head or spinal cord Injury) **Outpatient limit:** 30 visits combined per Insured per Calendar Year (up to 30 additional visits per condition may be considered for treatment of neurologic conditions when criteria for supplemental services are met)	

Inpatient and outpatient habilitative services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services) and are not services for a Mental Health Condition or Substance Use Disorder are covered. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Habilitative services for Mental Health Conditions or Substance Use Disorders are not subject to a visit limit. Such services are covered in the Mental Health or Substance Use Disorder Services benefit.

Habilitative services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

HEARING AIDS AND HEARING ASSISTIVE TECHNOLOGY SYSTEMS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limits: one hearing aid per ear per Insured every 36 months or more frequently if modifications to an existing hearing aid will not meet the needs of the Insured. One box of replacement batteries for each hearing aid per Insured per Calendar Year. Bone-conduction sound processors every 36 months, if necessary for appropriate amplification of the hearing loss. Ear molds and replacement ear molds up to four times per Calendar Year. Hearing assistive technology systems every 36 months, if necessary for appropriate amplification of hearing loss. Necessary diagnostic and treatment services at least twice per Calendar Year.	

Covered Services include the following:

- hearing aids and supplies;
- hearing assistive technology systems;
- diagnostic and treatment services including hearing tests appropriate for an Insured's age or developmental need;
- hearing aids checks and aided testing; and
- bone conduction sound processors when necessary for the treatment of hearing loss.

"Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device. "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Services and supplies that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. This coverage does not include routine hearing examinations or the cost of cords.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if

the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: 30 inpatient or outpatient respite care days per Insured Lifetime (limited to a maximum of five consecutive respite days at a time)	

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Insured and allow temporary relief to family members from the duties of caring for the Insured. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL AND AMBULATORY SURGICAL CENTER CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. An Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

NOTE: Ambulatory Surgical Center services may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, Ambulatory Surgical Center services will be covered as specified here.

INFUSION THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

Certain medications for outpatient infusion therapy may require prior authorization. Additionally, for coverage to be provided, prior authorization for some medications requires that infusion therapy be performed at an approved site of care, unless an exception is authorized. Site of care review is part of Our prior authorization process and may be a factor used to determine Medical Necessity.

"Approved site of care" means a Provider (such as standalone infusion sites, doctor's offices, home infusion or an approved Hospital-based infusion center) with which We have expressly identified or contracted to provide outpatient infusion therapy services in a more convenient, less costly manner while maintaining safety and efficiency. Contact Customer Service to verify which medications for outpatient infusion therapy require prior authorization and which Providers are an approved site of care.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient. When provided by an In-Network Provider, any Deductible, Copayment and/or Coinsurance do not apply to Medically Necessary Covered Services for management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum for each pregnancy.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered in the Preventive Care and Immunizations benefit.

Coverage of labor and delivery services provided at an Out-of-Network healthcare facility due solely to the diversion of the patient from an In-Network healthcare facility during a state or federally declared public health emergency is covered at the In-Network benefit level. If services were not covered at the In-Network benefit level, contact Customer Service for further information and guidance.

Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse Us the lesser of the amount described in the preceding sentence and the amount We have paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under the Policy).

You must notify Us within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with Us as needed to ensure Our ability to recover the costs of Covered Services received by You for which We are entitled to reimbursement. To notify Us, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Also refer to the Right of Reimbursement and Subrogation Recovery Section for more information.

Definitions
The following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

MEDICAL FOODS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Other services and supplies such as office visits and formula to treat severe intestinal malabsorption are otherwise covered under the appropriate provision in this Medical Benefits Section.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Inpatient and outpatient Mental Health and Substance Use Disorder Services, including Applied Behavioral Analysis (ABA) therapy services, behavioral health assessments and gender-affirmation treatment services are covered. "Gender-affirming treatment" is treatment whose purpose is to bring a person's outward appearance into closer alignment with that person's actual gender identity. Benefits include the following when provided for treatment of a Mental Health Condition:

- physical therapy;
- occupational therapy;
- speech therapy;
- radiology and laboratory services;
- durable medical equipment; and
- surgery.

Definitions
The following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. ABA therapy services must be provided by a licensed Provider qualified to prescribe and perform ABA therapy services.

Habilitative means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Mental Health and Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is Medically Necessary). These services include Habilitative and Rehabilitative services for Mental Health Conditions or Substance Use Disorders without any visit or day limits.

Mental Health Condition means any mental disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, including autism spectrum disorders and Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. Mental disorders that accompany an excluded diagnosis are covered.

Rehabilitative means inpatient or outpatient physical, occupational and speech therapy services to restore or improve lost function caused by Illness or Injury.

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a

Covered Service.

Substance Use Disorder means any substance-related disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child of the Policyholder or Policyholder's spouse are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, unless otherwise covered in the Preventive Care and Immunizations benefit.

NEWBORN HOME VISITS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Limit: within six months of age, at least one visit during the first three months of life with an opportunity to choose up to three more visits	

Home visits provided as part of the Oregon Health Authority's (OHA's) home visiting program are covered for enrolled newborns up to six months of age if:

- the newborn resides in an area of the state that is served by a universal newborn nurse home visiting program approved by the OHA; and
- the home visits are provided by an Oregon licensed registered nurse who is certified by the OHA to participate in that program.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Medically Necessary orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body are covered, including, but not limited to:

- braces;
- splints; and
- orthopedic appliances.

Additionally, some orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our Web site or contact Customer Service.

We may elect to provide benefits for a less costly alternative item. Covered Services do not include orthopedic shoes and off-the-shelf shoe inserts.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: 30 visits per Insured per Calendar Year	

Palliative care is covered when a Provider has assessed that an Insured is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for an Insured receiving palliative care remain covered the same as any other Illness or Injury.

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat an Insured diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- hemoglobin A1c testing and retinopathy screening with a diagnosis of diabetes;

- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Prosthetic devices for functional reasons are covered to replace a missing body part, including:

- artificial limbs;
- external or internal breast prostheses following a Mastectomy; and
- maxillofacial prostheses.

"Maxillofacial prostheses services" are restoration and management of head and facial structures that are not replaceable with living tissue and are defective because of disease, trauma, or birth or developmental deformities. Covered maxillofacial prostheses services must be either for the purpose of controlling or eliminating infection or pain or for restoring facial configuration or functions (e.g., speech, swallowing, chewing). Restoration of facial configuration that is cosmetic to improve on the normal range of conditions is not covered.

Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

REHABILITATIVE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Inpatient limit: 30 days per Insured per Calendar Year (up to 60 days per Calendar Year for head or spinal cord Injury) **Outpatient limit:** 30 visits combined per Insured per Calendar Year (up to 30 additional visits per condition may be considered for treatment of neurologic conditions when criteria for supplemental services are met)	

Inpatient and outpatient rehabilitative services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury that is not a Mental Health Condition or Substance Use Disorder. (Rehabilitative services for mental diagnoses are covered in the Mental Health or Substance Use Disorder Services benefit.)

Rehabilitative services are only:

- physical, occupational and speech therapy services (including services such as

massage when provided as a therapeutic intervention); and
- neurodevelopmental therapy by a Physician or Practitioner for neurological conditions that are not a Mental Health Condition or Substance Use Disorder (e.g., failure to thrive in newborn, lack of physiological development in childhood), including maintenance services if significant deterioration of an Insured's condition would result without the service.

Rehabilitative services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

REPRODUCTIVE HEALTH CARE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.

Reproductive health care services and supplies are covered, including abortion, vasectomy and screening for pregnancy that are not covered in the Preventive Care and Immunizations benefit.

SKILLED NURSING FACILITY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: 60 inpatient days per Insured per Calendar Year	

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is necessary.

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.
Limit: 20 visits combined per Insured per Calendar Year	

Chiropractic and osteopathic spinal manipulations are covered.

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Tobacco use cessation services not covered in the Preventive Care and Immunizations benefit are covered in this Tobacco Use Cessation benefit. A "tobacco use cessation service" means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:
  - either autologous (self-donor);
  - allogeneic (related or unrelated donor);
  - syngeneic (identical twin donor); or
  - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage; and

- transportation of the surgical harvesting team and the organ.

VIRTUAL CARE
Virtual care services are covered for the use of telehealth, telemedicine or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Upfront Benefits for office visits are not covered under this Virtual Care benefit. Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or the Providers that may offer lower-cost services, visit Our Web site or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.

Store and forward services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified here. All other Covered Services for an Insured receiving store and forward services will be covered the same as any other Illness or Injury.

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.

Telehealth services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified here. All other Covered Services for an Insured receiving telehealth services will be covered the same as any other Illness or Injury.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform when You are not in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your

Provider.

Telemedicine

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You will receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

Prescription Medications

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on Our Web site or by contacting Customer Service.

COPAYMENTS AND/OR COINSURANCE
After You meet any applicable Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Coinsurance will be applied toward the Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section.

You do not need to meet the Deductible when You fill a prescription for insulin, Preferred Generic or Generic Medications on the Drug List. Additionally, You do not need to meet any Deductible when You fill prescriptions for medications specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List found on Our Web site or by calling Customer Service.

The Deductible, Copayments and/or Coinsurance do not apply to Medically Necessary Prescription Medications for management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum for each pregnancy or for women's contraceptive methods that are not covered in the Preventive Care and Immunizations benefit or, for when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List found on Our Web site or by calling Customer Service.

When You fill a prescription for insulin, Your cost-share will not exceed $80 per a 30-day supply from a Participating Pharmacy or $240 per a 90-day supply from a Home Delivery Supplier.

For Self-Administrable Cancer Chemotherapy Medication, Your Coinsurance is the same as Your medical In-Network Coinsurance.

Prescription Medications from a Participating Pharmacy (for Each 30-Day Supply)

• You pay $15 for each Preferred Generic Medication on the Drug List
• You pay 10% for each Generic Medication on the Drug List
• You pay 20% for each Preferred Brand-Name Medication on the Drug List
• You pay 50% for each Brand-Name Medication on the Drug List
• You pay 40% for each Preferred Specialty Medication on the Drug List
• You pay 50% for each Specialty Medication on the Drug List

Prescription Medications from a Participating Home Delivery (Mail-Order) Supplier (for Each 90-Day Supply)

• You pay $45 for each Preferred Generic Medication on the Drug List
• You pay 10% for each Generic Medication on the Drug List
• You pay 20% for each Preferred Brand-Name Medication on the Drug List
• You pay 50% for each Brand-Name Medication on the Drug List

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which an Insured is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:
  - lancets;
  - test strips;
  - glucagon emergency kits; and
  - insulin syringes.
- therapeutic continuous glucose monitors and related supplies that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order;
- certain insulin pumps that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; related supplies and other insulin pumps are covered in the Durable Medical Equipment benefit;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medication;
- antiretroviral therapy medications obtained from either a Participating Pharmacy or Nonparticipating Pharmacy;
- immunizations for travel, occupation or residency in a foreign country; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the USPSTF, HRSA and CDC;
- certain preventive medications according to, and as recommended by the USPSTF, HRSA and CDC, that are on the Drug List and when obtained with a Prescription Order, such as:

- aspirin;
- fluoride;
- iron;
- folic acid supplements; and
- medications for tobacco use cessation.

- FDA-approved prescription and over-the-counter contraception methods, according to, and as recommended by the HRSA:

  - condoms;
  - diaphragm with spermicide;
  - sponge with spermicide;
  - cervical cap with spermicide;
  - spermicide;
  - oral contraceptives (combined pill, mini pill, and extended/continuous use pill);
  - contraceptive patch;
  - vaginal ring;
  - contraceptive shot/injection; and
  - emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products).

  You must submit a claim for reimbursement for the purchase of over-the-counter contraception items. To receive reimbursement for these items, complete a Prescription Medication claim form and mail the form and receipt to Us for processing. Our Prescription Medication claim form is available by visiting Our Web site or contacting Customer Service.

If Your Provider believes that Our covered preventive medications, including contraceptives, are medically inappropriate for You, You may request a coverage exception for an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit Our Web site or contact Customer Service.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Prior Authorization

Some Prescription Medications may require prior authorization before they are dispensed. We notify participating Providers, including Pharmacies, which Prescription Medications require prior authorization. Prescription Medications that require prior authorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require prior authorization will not be covered until they are prior authorized. For a list of medications that require prior authorization or if You have any questions, visit Our Web site or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from Our Drug List will be posted on Our Web site 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as

possible.

If You are taking a Prescription Medication while it is removed from the Drug List and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter or issuance of a black box warning by the Federal Drug Administration, We will continue to cover Your Prescription Medication for the time period required to use Our drug list exception process to request continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

Drug List Exception Process
Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

To request coverage for a Prescription Medication not on the Drug List, You or Your Provider will need to request prior authorization so that We can determine that a Prescription Medication not on the Drug List is Medically Necessary. Your Prescription Medication not on the Drug List may be considered Medically Necessary if:

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request prior authorization by calling Customer Service or by completing and submitting the form on Our Web site.

Once prior authorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your benefit and will apply toward any Deductible or Out-of-Pocket Maximum.

Your Responsibility for Cost Differences of Chosen Medications
You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or

- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or the Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

Pharmacy Network Information
A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on Our Web site or by contacting Customer Service.

Nonparticipating Pharmacies are not covered under Your Prescription Medications benefit.

For any Specialty Medication for which the FDA has not restricted distribution to certain Providers, if a Participating Pharmacy demonstrates the ability to provide the same level of services (i.e., special handling, provider coordination, and/or patient education) as a Specialty Pharmacy and accepts all Specialty Pharmacy network terms, then that Specialty Medication from that Participating Pharmacy will be eligible for coverage.

You must present Your identification card to identify Yourself as Our Insured when obtaining Prescription Medications from a Participating Pharmacy, Specialty Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Claims Submitted Electronically
Participating Pharmacies will submit claims electronically. Present Your identification card at a Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase.

Claims Not Submitted Electronically
When a claim is not submitted electronically, You pay for the Prescription Medication in full at the time of purchase. For reimbursement, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to Us. To find the Prescription Medication claim form, visit Our Web site or contact Customer Service.

We will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from a Participating Pharmacy.

Home Delivery (Mail-Order)
You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

To buy Prescription Medications through the mail, send all of the following items to a Home Delivery Supplier at the address shown on the prescription home delivery form

(which also includes refill instructions) available on Our Web site:

- a completed prescription home delivery form;
- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

Prescription Medications Dispensed by Excluded Pharmacies
We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy.

Refills
Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription;
    - except, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Home Delivery Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.
- receive maintenance medications for chronic conditions, You may qualify for Our prescription refill synchronization which allows refilling Prescription Medications from a Pharmacy on the same day of the month.

For further information on prescription refills or refill synchronization, please call Customer Service.

Discounts or Manufacturer Coupons
Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon does not apply toward the Deductible or Out-of-Pocket Maximum when purchased through Our Specialty Pharmacy.

LIMITATIONS
The following limitations apply to this Prescription Medications Section, except for certain preventive medications as specified in the Covered Prescription Medications Section:

Prescription Medication Supply Limits

- **30-Day Supply Limit:**
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. The first fill is allowed at a Participating Pharmacy. Additional fills must be provided at a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, please visit Our Web site or contact Customer Service. Specialty Medications are not allowed through home delivery.
- **3-Month Supply Limit:**
  - **Prescription Contraceptives** – the largest allowable quantity for the first fill of a prescription contraceptive purchased from a Participating Pharmacy or Home Delivery Supplier is a three-month supply (which may be dispensed in a Provider's office, if available). After the first fill, a 12-month supply is allowed for subsequent fills of the same contraceptive. The Copayment and/or Coinsurance, if applicable, is based on each 30-day supply from a Participating Pharmacy and each 90-day supply from a Home Delivery Supplier.
- **90-Day Supply Limit:**
  - **Participating Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
  - **Home Delivery (Mail-Order) Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Multiple-Month Supply** – except for prescription contraceptives, the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.
- **Maximum Quantity Limit:**
  - For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.

- For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Insured's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
- Any amount over the established maximum quantity is not covered, except if the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

EXCLUSIONS
The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders
Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes
Prescription Medications used for cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

Devices or Appliances
Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents
Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics
Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications
Foreign Prescription Medications are not covered, except for the following:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not

covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications That Are Not Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Nonprescription medications that by law do not require a Prescription Order are not covered, except for the following:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications (except for over-the-counter contraceptives);
- vitamins (except for folic acid supplements);
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter (except for over-the-counter contraceptives) in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

NOTE: Over-the-counter contraceptives and folic acid supplements are covered under this Prescription Medications Section.

Prescription Medications Dispensed by a Nonparticipating Pharmacy

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process, Prescription Medications that are not on the Drug List are not covered.

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Therapeutic Alternatives
Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives, or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply for:

- hormonal contraceptive patches; or
- self-administered hormonal contraceptives prescribed by a Pharmacist.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Home Delivery Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Home Delivery Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Drug List means Our list of selected Prescription Medications. We established Our Drug List and We review and update it routinely. It is available on Our Web site or by calling Customer Service. Medications are reviewed and selected for inclusion on Our Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Home Delivery Supplier means a home delivery (mail-order) Pharmacy with which We have contracted for home delivery (mail-order) services.

Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Participating Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. To find a Participating Pharmacy, visit Our Web site or contact Customer Service.

Pharmacist means an individual licensed to dispense, prescribe, and/or administer Prescription Medications, counsel a patient about how the medication works, any possible adverse effects and perform other duties as described in their state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists who review the medical and scientific literature regarding medication use. The P&T Committee also provides input and oversight of the development of Our Drug List and medication policies. Additionally, the P&T Committee is free from conflict of interest of drug manufacturers and the majority of whom are also free from conflict of interest of Your coverage.

Preferred Brand-Name Medication and Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by Us) as a Brand-Name Medication based on manufacturer and price.

Preferred Generic Medication and Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by Us) as a Generic Medication. "Equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will decide.

Preferred Specialty Medications and Specialty Medications mean medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our Web site or contact Customer Service.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or

- are specifically included on Our Drug List.

Prescription Order means a written prescription, oral or electronic request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medication, Self-Administrable Medication, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our Web site or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Brand-Name Medication benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Specialty Medication benefit level.

Pediatric Vision Services

Vision Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. The BlueCard Program does not apply to Vision Services covered in this Pediatric Vision Services benefit. Benefits will be paid in this Pediatric Vision Services benefit, not any other provision, if a service or supply is covered by both.

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

Accessing Providers
You are not restricted in Your choice of Provider for vision care or treatment. You control Your out-of-pocket expenses by choosing a "VSP Doctor."

- **VSP Doctor.** Choosing VSP Doctors saves You the most in Your out-of-pocket expenses. VSP Doctors will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network Provider.** Choosing Out-of-Network Providers means You are responsible for all expenses.

VISION EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Frequency Period: one examination every Calendar Year	

Professional comprehensive routine eye examination or visual analysis is covered, including:

- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

VISION HARDWARE

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Frame Frequency Period: one pair of frames every Calendar Year	
Lens Frequency Period: one pair of lenses every Calendar Year	

Hardware including frames, contacts and lenses is covered, subject to any specified limits as explained in the following paragraphs:

Frames
Frames from VSP Doctors are limited to the Otis & Piper Eyewear Collection. Frames

from VSP Doctors that are not from the Otis & Piper Collection are not covered, and You will pay the full cost of the frame minus any discount.

Lenses
Standard glass, plastic or polycarbonate lenses for one of the following:

- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- photochromic lenses;
- elective contacts;* or
- Necessary Contact Lenses.*

Any of the following lens enhancements:

- scratch coating;
- UV (ultraviolet) protection; and
- tinting.

*Contact lenses are limited to one of the following:

- for elective contact lenses:
  - standard (one pair annually);
  - monthly (six-month supply);
  - bi-weekly (three-month supply); or
  - dailies (three-month supply).
- for Necessary Contact Lenses, a Calendar Year supply if You have a specific condition for which contact lenses provide better visual correction.

Necessary Contact Lenses and elective contact lenses are in lieu of all other frame and lens benefits. When You receive contact lenses, You will not be eligible for any frames or other types of lenses again until the next Calendar Year.

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Frequency Period: one contact lens evaluation and fitting examination every Calendar Year	

Services and supplies for contact lens evaluation and fitting examinations are covered.

LOW VISION BENEFIT
Low vision benefits for Insureds are covered if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your VSP Doctor for more details and to see if You fall within this category. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

Supplemental Examinations (Testing)

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Frequency Period: every two Calendar Years	

Supplemental examinations (complete low vision testing, analysis and diagnosis) which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

Supplemental Aids

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** Not covered.
Frequency Period: every two Calendar Years	

Low vision aids, including, but not limited to:

- optical;
- non-optical; and
- associated training.

DISCOUNTS FROM VSP DOCTORS

Discounts are available for the following services or supplies when received from a VSP Doctor:

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination within 12 months if necessary, at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do **not** apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:
  - contact lens solutions;
  - cases;
  - cleaning products; or
  - repairs of spectacle lenses or frames.

THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.

PEDIATRIC VISION CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for

payment.

EXCLUSIONS
The following exclusions apply to this Pediatric Vision Services Section and are not covered:

Certain Contact Lens Expenses
- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Corneal Refractive Therapy (CRT)
Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements
Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal lenses.

Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training
Except as provided in the Low Vision benefit, orthoptics, vision training and any associated supplemental testing are not covered.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements
Replacement of any lost, stolen or broken lenses and/or frames.

Two Pair of Glasses Instead of Bifocals

DEFINITIONS
The following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means the amount that VSP Doctors have contractually agreed to accept as payment in full for Covered Services.

Charges in excess of the Allowed Amount and charges from an Out-of-Network Provider are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact VSP.

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Necessary Contact Lenses means contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than cosmetic purposes.

Out-of-Network Provider means a Provider who is not a VSP Doctor. We do not cover services provided by Out-of-Network Providers.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide vision services.

Vision Service means those vision-related services, supplies, treatment or accommodation provided for the diagnosis or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of their license.

VSP Doctor means a Physician or Practitioner (for example, an ophthalmologist or optometrist) who is duly licensed and who has contracted with VSP to provide vision care services and/or vision care materials to Insureds in accordance with the provisions of this coverage.

Pediatric Dental Services

Dental Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. The BlueCard Program does not apply to Dental Services covered in this Pediatric Dental Services benefit. Benefits will be paid in this Pediatric Dental Services benefit, not any other provision, if a service or supply is covered by both.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: No charge.	**Payment:** Not covered.

Preventive and diagnostic Dental Services are covered, subject to any specified limits as explained in the following:

- Bitewing x-ray sets, limited to one set per Insured per Calendar Year.
- Complete panoramic or intra-oral mouth x-rays, limited to one in a five-year period. Posterior-anterior or lateral skull and facial bone survey film, limited to one every three years (based on date of service).
- Routine radiology, limited to one set per Insured per Calendar Year.
- Preventive and problem focused oral examinations, limited to two per Insured per Calendar Year.
- Emergency care: oral examination and follow-up related dental visits. (Includes up to 10 periapical x-rays per emergency.)
- Cleanings limited to two* per Insured per Calendar Year.

  *A third cleaning may be covered, in the same Calendar Year, for Insureds with one or more of the following conditions:

  - coronary atherosclerosis;
  - diabetes;
  - hypertensive heart disease; or
  - pregnancy.

- Sealants, limited to permanent molars. One sealant treatment per molar every five years.
- Space maintainers (fixed or removable). Replacement of lost or damaged removable space maintainers is not covered.
- Topical fluoride application limited to two treatments per Insured per Calendar Year. For Insureds with limited access to a dental Practitioner, topical fluoride varnish may be applied by a medical Practitioner during a medical office visit.

BASIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: You pay 20% of the Allowed Amount.	**Payment:** Not covered.

Basic Dental Services are covered, subject to any specified limits as explained in the

following:

- Oral surgical services consisting of the following are covered.

- extractions of teeth including alveoloplasty in conjunction with the extraction;
  - impactions;
  - alveoloplasty not in conjunction with extraction of teeth;
  - vestibuloplasty;
  - residual root removal;
  - tooth re-implantation (provided only for traumatic avulsion);
  - collection of biopsies;
  - frenulectomy or frenuloplasty (limited to twice per arch per Insured Lifetime; and maxillary labial frenulectomy);
  - excision of pericoronal gingival.

- Emergency treatment for acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums, or a tooth that has been avulsed (knocked out). Routine dental treatment or treatment of incipient (early stage) decay does not constitute emergency care.
- Endodontic services consisting of the following are covered if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures:

  - apicoectomy;
  - apexification limited to five treatments on permanent teeth;
  - endodontic therapy on anterior and bicuspid permanent teeth;
  - endodontic therapy on molars covered only for the first and second molars;
  - retrograde fillings are covered only when done in conjunction with a covered apicoectomy of an anterior tooth;
  - pulpal therapy limited to primary teeth;
  - root canal treatment.

  Endodontic benefits will **not** be provided for retreatment of a previous root canal or apicoectomy/periradicular surgery for bicuspid or molars.

- Fillings consisting of resin-based composite and amalgam restorations. Regardless of number or combination of restorations, a surface is covered once in each treatment episode. Includes:

  - occlusal adjustments and polishing of restorations;
  - resin-based composite crowns on anterior teeth.

- General dental anesthesia or intravenous sedation covered depending on concurrent needs (for example: age, physical, medical or mental status of the patient, or the complexity of the procedure). Oral pre-medication anesthesia for conscious sedation limited up to four times per Insured per Calendar Year.
- Nitrous Oxide (per date of service, not length of time).
- Periodontal services consisting of:

  - debridement limited to once in a two-year period;
  - gingivectomy and gingivoplasty limited to severe gingival hyperplasia with criteria

and includes six months of routine post-op care;
- scaling and root planing is limited to once in a two-year period; and
- periodontal maintenance limited to two* per Calendar Year.

*A third periodontal maintenance may be covered, in the same Calendar Year, for Insureds with one or more of the following conditions:

- coronary atherosclerosis;
- diabetes;
- hypertensive heart disease; or
- pregnancy.

MAJOR DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: You pay 50% of the Allowed Amount.	**Payment:** Not covered.

Major Dental Services are covered, subject to any specified limits as explained in the following:

- Bridges (fixed partial dentures), covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment.
- Crowns, inlays and onlays. Core buildup is covered only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup.

  - crowns limited to four (including replacement crowns) in a seven-year period;
  - acrylic heat or light cured crowns are covered for permanent anterior teeth only;
  - crown repair, by report is limited to anterior teeth only;
  - inlays and onlays limited to once every five years (with exception of trauma);

  benefits will not be provided for:

  - replacement made fewer than seven years after placement;
  - crowns in cases of advanced periodontal disease or when a poor crown/root; and
  - additional procedures to construct a new crown under an existing partial denture framework.

- Dentures, full and partial. Includes:

  - repairs covered within six months of initial delivery, limited to once per Insured Lifetime for repairing broken complete denture base, partial resin denture base, partial cast framework, repairing or replacing broken clasp or adding clasp to existing partial denture;
  - reline procedures, limited to once in a three-year period;
  - rebase procedures covered if reline procedure is inadequate to resolve issue,

limited to once in a three-year period.

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT
In-Network Dentist Claims and Reimbursement
You must present Your identification card to an In-Network Dentist and furnish any additional information requested. The In-Network Dentist will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Dentist directly for Covered Services. These In-Network Dentists may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Dentists have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

EXCLUSIONS
The following exclusions apply to this Pediatric Dental Services Section and are not covered:

Aesthetic Dental Procedures
Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Amalgam or Composite Restoration and a Crown on the Same Tooth

Antimicrobial Agents
Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Behavior Management

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Core Buildup for a Crown (Unless Crown is Covered)

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies are not covered, except for Dentally Appropriate treatment of the following:

- to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Desensitizing
Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Endodontic Endosseous Implants

Experimental or Investigational Services

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping As A Separate Charge

Medications and Supplies
Charges in connection with medications and supplies, including, but not limited to:

- take home drugs;
- pre-medications; and
- therapeutic drug injections.

Occlusal Treatment
Dental occlusion services and supplies are not covered, including, but not limited to:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Orthodontic Dental Services
Except in the case of cleft palate or cleft palate with cleft lip, orthodontic services and supplies are not covered, including, but not limited to:

- correction of malocclusion;
- craniomandibular orthopedic treatment;

- other orthodontic treatment;
- preventive orthodontic procedures; and
- procedures for tooth movement, regardless of purpose.

Overhang Removal

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures, except when documentation of oral disease exists; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Pulp Vitality Tests

Replacements
Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures and retainers.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

- alveoloplasty in conjunction with extractions (separate from the extraction);
- excision of soft tissue lesions;
- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with TMJ disorder treatment.

Therapeutic Drug Injections for Dental Services

Tobacco or Nutritional Counseling for the Control and Prevention of Oral Disease

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Treatment of Post-Surgical Complications Due to Unusual Circumstances

Veneers

DEFINITIONS
The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means the amount In-Network Dentists have contractually agreed to accept as payment in full for Covered Services.

Charges in excess of the Allowed Amount and charges from an Out-of-Network Dentists are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact Customer Service.

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other Provider practicing within the scope of their license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Insured's condition; and
- not primarily for the convenience of the Insured, Insured's Family or Provider.

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE IN THIS POLICY.

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their respective state licensing board, to independently bill third-parties.

In-Network Dentist means a Dentist who has an effective participating contract with Us that designates them as a Dentist of Your network, to provide services and supplies to Insureds in accordance with the provisions of this coverage.

Out-of-Network Dentist means a Dentist who is not an In-Network Dentist. We do not cover services provided by Out-of-Network Dentists.

Accidental Death Benefit

Subject to the terms and conditions of this Section, We will pay the benefit shown here when We receive proof of death by Accidental Bodily Injury of the Policyholder, enrolled spouse, enrolled domestic partner, or an enrolled child as described in the following paragraphs.

BENEFIT
The following conditions must be met in order for this benefit to be payable:

- the death must result from Accidental Bodily Injury;
- the Accidental Bodily Injury must occur while covered by this Policy; and
- the death must occur within 365 days after the date of the Accidental Bodily Injury.

With proof of death by Accidental Bodily Injury, We pay the following benefit:

Policyholder (age 18 or older)	$10,000
Enrolled Spouse	$10,000
Enrolled Domestic Partner	$10,000
Enrolled Child	$2,500

EXCLUSIONS
Even though a death results from Accidental Bodily Injury, no payment will be made according to this benefit if such Injury is caused by, or occurs as a result of, any of the following:

- suicide, intentionally self-inflicted Injury or any attempt to injure oneself, while sane or insane;
- active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- insurrection, war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- committing or attempting to commit an assault or felony;
- any sickness or pregnancy existing at the time of the accident;
- voluntary use or consumption of any poison, chemical compound or drug, except a Prescription Medication used or consumed in accordance with the directions of the prescribing Physician;
- heart attack (including, but not limited to, myocardial infarction) or stroke (including, but not limited to, cerebral infarction);
- diagnostic test, medical or surgical treatment; or
- bodily infirmity or disease from bacterial or viral infections, other than infection caused from an Injury sustained while covered by this benefit.

GENERAL PROVISIONS
Notice of Claim
Written notice of any loss resulting in a claim being filed with this benefit must be given

to Us within 20 days after the loss occurs, or as soon as reasonably possible.

Claim Forms
When notice of claim is received, We will send You the forms for filing proof of loss. If the forms are not received within 15 days, You can send Us written proof of loss without waiting for the forms.

Proof of Loss
You must give Us written proof of loss within 90 days after the date of the loss for which a claim is made. We will not deny or reduce any claim if it was not reasonably possible for You to give Us proof in the time required. In any event, You must give Us proof within one year after it is due, unless You are incapable of doing so.

Timely Payment of Claims
Losses covered by this benefit will be paid as soon as We receive written proof of such loss.

Payment of Claims
Losses covered by this benefit will be paid to You. Payment due at the time of Your death will be paid to Your estate.

Autopsy
We have the right to require an autopsy at Our expense where it is not forbidden by law.

Legal Actions
No legal action may be brought to recover on this benefit until 60 days after proof of loss has been furnished. No action may be brought after three years from the time written proof of loss is required to be furnished.

DEFINITIONS
The following definition applies only to this Accidental Death Benefit Section:

Accidental Bodily Injury means immediate traumatic physical damage to the body which results directly from an unexpected and unintentional event, and which is independent of disease, bodily infirmity or any other cause.

General Exclusions

The following are the general exclusions from coverage. Other exclusions may apply as described elsewhere in this Policy.

SPECIFIC EXCLUSIONS
The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- a preventive service as specified in the Preventive Care and Immunizations benefit and/or in the Prescription Medications Section; or
- services and supplies furnished in an emergency room for stabilization of a patient.

Activity Therapy
The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps
Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Policy.

Assisted Reproductive Technologies
Assisted reproductive technologies, regardless of underlying condition or circumstance are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Aviation
Services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing) are not covered, unless the injured Insured is a passenger on a scheduled commercial airline flight or air ambulance.

Continuous Glucose Monitors
Except as provided in the Prescription Medications Section, continuous glucose monitors (whether therapeutic or non-therapeutic) are not covered.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies are not covered, except for the treatment of the following:

- congenital anomaly;
- craniofacial anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury;
- for one attempt to correct a scar or defect that resulted from an accidental Injury or treatment for an accidental Injury (more than one attempt is covered if Medically Necessary);
- for one attempt to correct a scar or defect on the head or neck that resulted from a surgery (more than one attempt is covered if Medically Necessary); or
- related to breast reconstruction following a Medically Necessary Mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance and that are not Medically Necessary.

"Mastectomy" means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with

activities of daily living is not covered.

Dental Services
Except as provided in the Pediatric Dental Services Section or the Medical Benefits Section, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under this Policy or after Your termination under this Policy.

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

Government Programs
Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this Policy) by any federal, state or government program are not covered.

Additionally, government facilities or government facilities outside the service area are not covered, except for the following:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hearing Care
Except as provided in the Medical Benefits Section, hearing care is not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- mental health and substance use disorders; or
- for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** an activity where the Insured is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports, as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to an Insured (whether or not the Insured makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person.

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling benefit or as required by law, such as for Preventive Care and Immunizations, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including revisions, reversals, and treatment of complications); or
- programs.

Orthognathic Surgery
Orthognathic surgery is not covered, except for the treatment of the following:

- orthognathic surgery due to an Injury;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomaly (including craniofacial anomalies).

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Out-of-Network Services
Except as specified for Out-of-Network Providers in the Medical Benefits Section, Out-of-Network services are not covered.

Over-the-Counter Contraceptives
Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered unless approved by the FDA.

Personal Items
Items that are primarily for comfort, convenience, contentment, cosmetics, hygiene,

environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate an Insured, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Insured's long-term social needs when rendered by individuals who are not Providers.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and

- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational Injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except for Medically Necessary mental health services and supplies for a diagnosis of sexual dysfunction which are covered in the Mental Health or Substance Use Disorder Services benefit, services and supplies are not covered for or in connection with sexual dysfunction.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. "Maternity and related medical services" include otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care and/or Right of Reimbursement and Subrogation Recovery Sections for more information.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for TMJ disorder treatment.

Therapies, Counseling and Training
Except as provided in the Individual Assistance Program (IAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- job skills or sensitivity training.

Third-Party Liability
Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Varicose Vein Treatment
Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care
Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

War-Related Conditions
The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the Insured's military or veterans coverage.

Work Injury/Illness
When You have filed a claim with workers' compensation and Your work-related Illness or Injury has been accepted by workers' compensation, any services and supplies arising out of that accepted work-related Illness or Injury are not covered. Subject to

applicable state or federal workers' compensation law, services and supplies received for work-related Illnesses or Injuries where You and Your Enrolled Dependent(s) fail to file a claim for workers' compensation benefits are not covered. The only exception is if You and Your Enrolled Dependent(s) are exempt from state or federal workers' compensation law.

Policy and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT
When claims are submitted and payment is due, We decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under this Policy has died, is a minor or is incompetent, We may pay the benefits up to $1,000 to a relative by blood or marriage of that person when We believe that person is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Us to the extent of the payment.

In-Network Provider Claims and Reimbursement
You must present Your identification card to an In-Network Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Provider Claims and Reimbursement
Services provided by Out-of-Network Providers are not covered, except as specifically noted in the Medical Benefits Section. In order for Us to pay for eligible Covered Services received from an Out-of-Network Provider, You or the Out-of-Network Provider must first send Us a claim. We pay Out-of-Network Providers directly for Covered Services. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the place of service;
- the date treatment was given;
- the diagnosis;
- the patient's name;
- Your identification number; and
- the group number.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send Us the claim.

Out-of-Network Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You generally are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. (See Services Received From An Oregon Out-of-Network Provider In An In-Network Healthcare Facility in the Medical Benefits Section for an exception to

balance billing.) For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Reimbursement Examples by Provider
Here are reimbursement examples for In-Network or Out-of-Network Providers. Let's assume We pay 70 percent of the Allowed Amount for In-Network Providers, 0 percent for Out-of-Network Providers for non-covered services, and 50 percent of the Allowed Amount for Out-of-Network Providers for eligible Covered Services. The benefit table would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** Not covered.

In this example, the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. We will assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum:

- In-Network Provider: We would pay 70 percent of the Allowed Amount and You would pay 30 percent of the Allowed Amount, as follows:
  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount We pay (70% of the $4,000 Allowed Amount): $2,800
  - **Amount You pay** (30% of the $4,000 Allowed Amount): **$1,200**
  - Total: $5,000
- Out-of-Network Provider (non-Covered Services): We would pay 0 percent of the benefits not covered and You would pay 100 percent of the billed charges, as follows:
  - Amount We pay (0% of the $5,000 billed charge): $0
  - **Amount You pay** (100% of the $5,000 billed charge): **$5,000**
  - Total: $5,000
- Out-of-Network Provider (eligible Covered Services): We would pay 50 percent of the Allowed Amount. (For purposes of this example, We assume $4,000 also is the Reasonable Charge upon which the Out-of-Network Provider's Allowed Amount is based. The Reasonable Charge can be lower than the In-Network Allowed Amount.) Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 50 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:
  - Amount We pay (50% of the $4,000 Allowed Amount): $2,000
  - **Amount You pay** (50% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$3,000**
  - Total: $5,000

The actual benefits may vary, so review the benefit sections to determine how Your benefits are paid. For example, the Allowed Amount may vary for a Covered Service depending upon the selected Provider.

Timely Filing of Claims
Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

Claim Determinations
Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If We require additional information to process the claim, We must allow You at least 45 days to provide it to Us. If We do not receive the requested information within the time We have allowed, We will deny the claim.

Explanation of Benefits
We use a form called an Explanation of Benefits (EOB). It is not a bill. It explains how a claim was processed and includes the date of service, the amount billed, the amount covered, the amount We paid and any balance You may be responsible for. If We deny all or part of a claim, the reason for Our action will be stated on the EOB. The EOB will also include instructions for filing an appeal or Grievance if You disagree with the action.

CONTINUITY OF CARE
You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

We will notify You of Your right to receive continued care from the Provider or You may contact Us with a need for continued care. Coverage under this Continuity of Care

provision will be subject to the benefits of this Policy and provided on the same terms and conditions as any other In-Network Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDERS

If a Covered Service is Medically Necessary, but there is not reasonable access to an In-Network Provider, You may be able to receive coverage for such services from an Out-of-Network Provider. To receive coverage, You or the Provider must request prior approval before You receive services. When prior approved, Covered Services received from the Out-of-Network Provider will be reimbursed at the In-Network benefit level.

If the Out-of-Network Provider does not have a contract with Us or the local Blue Cross and/or Blue Shield Licensee, You may be responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount, in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. Any amounts You pay for non-Covered Services or in excess of the Allowed Amount do not apply toward the Deductible or Out-of-Pocket Maximum. Contact Customer Service for further information and guidance.

NOTE: It is Your responsibility to obtain prior approval for any such Out-of-Network Provider services. If You do not obtain prior approval, services will not be covered. The Out-of-Network Provider can bill You directly and You will have to pay the total cost of the services. These costs do not apply toward the Deductible or Out-of-Pocket Maximum.

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You obtain health care services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside of Our service area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

We cover only limited healthcare services received outside of Our service area. As used in this section, "Out-of-Area Covered Healthcare Services" are limited to emergency care (including ambulance) and urgent care obtained outside the geographic area We or one of Our Affiliates serve. Out-of-Area Covered Healthcare Services also include Out-of-Network services We have prior approved when You otherwise would not have reasonable access to an In-Network Provider. Any other

services will not be covered when processed through any Inter-Plan Arrangements.

BlueCard Program
Under the BlueCard Program, when You receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Policy. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above. An In-Network Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services, so there are no claim forms for You to fill out. You will be responsible for any Deductible, Copayment and/or Coinsurance, if applicable.

Emergency Care Services: If you experience a medical emergency while traveling outside the service area, go to the nearest emergency or urgent care facility.

When You receive Out-of-Area Covered Healthcare Services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for the Out-of-Area Covered Healthcare Services is calculated based on the lower of:

- The billed charges for Your Out-of-Area Covered Healthcare Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside Our Service Area
- Your Liability Calculation. When Out-of-Area Covered Healthcare Services are provided outside of Our service area by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network emergency

services.

- Exceptions. In certain situations, We may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment We would make if the health care services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the United States, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the United States, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of service, You must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the United States will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at www.bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven

days a week.

CLAIMS RECOVERY
If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We reserve the right to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Policyholder or any Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to the experience of the pool by which You are rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This Claims Recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the Right of Reimbursement and Subrogation Recovery provision for additional information.

LEGAL ACTION
No action at law or in equity will be brought to recover under this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY
As used herein, the term "third-party," means any party that is, or may be, or is claimed to be responsible for Illness or Injuries to You. Such Illness or Injuries are referred to as "third-party Injuries." Third-party includes any party responsible for payment of expenses associated with the care or treatment of third-party Injuries.

If We pay benefits under this Policy to You for expenses incurred due to third-party Injuries, then We retain the right to repayment of the full cost, to the extent permitted by applicable law, of all benefits provided by Us on Your behalf that are associated with the third-party Injuries. To the extent that such third-party Injuries are the result of a motor vehicle accident, and to the extent that Our right to repayment is governed by Oregon law, We retain the right to repayment of the cost of benefits provided from any settlement, judgement, or other payment received by You to the extent that such settlement, judgement, or other payment exceeds the amount that fully compensates You for Your Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including, but not limited to:

- payments made by a third-party or any insurance company on behalf of the third-party;
- any payments or awards from an uninsured or underinsured motorist coverage policy;
- any workers' compensation or disability award or settlement;

- medical payments coverage from any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate You for Injuries resulting from an accident or alleged negligence.

By accepting benefits under this Policy, You specifically acknowledge Our right of subrogation. When We pay health care benefits for expenses incurred due to third-party Injuries, We shall be subrogated to Your right of recovery against any party to the extent of the full cost, to the extent permitted by applicable law, of all benefits provided by Us. We may proceed against any party with or without Your consent.

By accepting benefits under this Policy, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when We have paid benefits due to third-party Injuries and You or Your representative have recovered any amounts from a third-party. By providing any benefit under this Policy, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent permitted by applicable law of the full cost of all benefits provided by Us. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

In order to secure Our recovery rights, You agree to assign to Us any benefits or claims or rights of recovery You have in any automobile policy or other coverage, to the full extent permitted by applicable law of Our subrogation and reimbursement claims. This assignment allows Us to pursue any claim You may have, whether or not You choose to pursue the claim.

Advancement of Benefits
If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, We may advance benefits pending the resolution of a claim to the right of recovery and all of the following conditions apply:

- By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid, to the extent permitted by applicable law, out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits.
- You or Your representative agree to give Us a first-priority lien on any recovery, settlement, judgment or other source of compensation which may be received from any party to the extent permitted by applicable law of the full cost of all benefits associated with third-party Injuries provided by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Further, You agree to pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to Us as reimbursement for the full cost, to the extent permitted by applicable law, of all benefits associated with third-party Injuries paid by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Our rights apply without regard to the source of payment for medical expenses,

whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Insured and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery to the extent permitted by applicable law. This applies regardless of whether:

- the third-party or third-party's insurer admits liability;
- the health care expenses are itemized or expressly excluded in the recovery; or
- the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Policy.

- We will not reduce Our reimbursement or subrogation due to Your not being made whole unless such a reduction is required by applicable law. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- By accepting benefits under this Policy, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
- You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). Unless prohibited by applicable law, if We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:

  - the filing of a lawsuit;
  - the making of a claim against any third-party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Illness or Injury that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.

- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover the full cost of all benefits paid by Us under this Policy to the extent permitted by applicable law without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from Our recovery, and We are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by You to pursue Your claim or lawsuit against any third-party. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by Us in addition to costs and attorney's fees incurred by Us in obtaining repayment to the extent permitted by applicable law.

Motor Vehicle Coverage
If You are involved in a motor vehicle accident, You may have rights both with motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this Right of Reimbursement and Subrogation Recovery provision still applies.

Workers' Compensation
Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify Us in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- We will expedite prior authorization during the interim period before workers' compensation initially accepts or denies Your work-related Injury or occupational disease.
- If the entity providing workers' compensation coverage denies Your claim as a non-compensable workers' compensation claim and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in a segregated account for Us.

Fees and Expenses
We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that We pay a proportional share of attorney's fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. We have discretion whether to grant such requests.

Future Medical Expenses
Unless prohibited by applicable law, benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which We would normally provide benefits. However, the amount of any Covered Services excluded in this provision will not exceed the amount of Your recovery.

COORDINATION OF BENEFITS
If You are covered by any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits in this Policy and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Definitions
The following are definitions that apply to this Coordination of Benefits provision:

Allowable Expense means, with regard to services that are covered in full or part by this Policy or any Other Plan(s) covering You, the amount on which that plan would base its benefit payment for a service, including Coinsurance or Copayments, if any, and without reduction for any applicable Deductible. The following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- Any expenses for other types of coverage or benefits when this coverage restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this Policy.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and We are notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. A Claim Determination Period does not include any time when You were not enrolled under the Policy.

Custodial Parent means the parent awarded custody of a child by a court decree. In the

absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

Other Plan means any of the following with which this coverage coordinates benefits:

- group, blanket, individual, and franchise health insurance and prepayment coverage;
- group, blanket, individual, and franchise health maintenance organization or other closed panel plan coverage;
- Group-Type Coverage;
- labor-management trust plan, union welfare plan, employer organization plan, and employee benefit organization plan coverage;
- uninsured group or Group-Type Coverage arrangements;
- medical care components of group long-term care coverage, such as skilled nursing care; and
- hospital, medical, and surgical benefits of Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- independent noncoordinated hospital indemnity coverage or other fixed indemnity coverage;
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- group long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services received;
- accident only coverage;
- specified disease or specified accident coverage;
- Medicare supplement coverage;
- a Medicaid state plan; or
- a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the plan that must determine its benefits for Your health care before the benefits of an Other Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

- the plan has no order of benefit determination provision;
- the plan is prohibited by law from using any order of benefits determination provision

other than the one included herein and the plan contains a different order of benefit determination; or
- both plans use the order of benefit determination provision included herein and by that provision the plan determines its benefits first.

Secondary Plan means a plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year means Calendar Year (January 1 through December 31).

Order of Benefit Determination
The order of benefit determination is identified by using the first of the following rules that apply:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan for which You are covered as a dependent.

Dependent Coverage: Except where the order of benefit determination is being identified among plans covering You as the dependent of Your parents who are separated or divorced and/or those parents' spouses, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents covering You as a dependent have the same Birthday, the plan of the parent who has been covered by their plan longer shall be primary to the plan of the parent who has been covered by their plan for a shorter period.

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If benefits have been paid or provided by a plan before it has actual knowledge of the term in the court decree, these rules do not apply until that plan's next contract Year.

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by their plan longer shall be primary to the plan of the other parent. If the Other Plan does not contain this dependent rule, the Other Plan's dependent rule will govern.

If none of the above dependent rules identifies the order of benefits determination among plans covering You as the dependent of parents who are separated or divorced and/or those parents' spouses:

- The plan of Your Custodial Parent shall be primary to the plan of Your Custodial Parent's spouse.
- The plan of Your Custodial Parent's spouse shall be primary to the plan of Your noncustodial parent.
- Then the plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered by more than one plan of individuals who are not Your parents, the above Dependent Coverage rules shall be applied to determine the order of benefit determination as if those individuals were Your parents.

If You are covered by either or both of Your parents' plans and as a dependent under Your spouse's plan, the rule in the Longer/shorter length of coverage section below shall be applied to determine the order of benefit determination. If Your coverage under Your spouse's plan began on the same date as Your coverage under one or both of Your parents' plans, the order of benefit determination between or among those plans shall be determined by applying the birthday rule in the first paragraph of this Dependent Coverage section to Your parent(s) and spouse.

Active/inactive employees: A plan that covers You as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan by which You are covered as a laid off or retired employee (or as the dependent of a laid off or retired employee). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Continuation coverage: A plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a plan that is providing continuation coverage. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the plan that has covered You for the longer period of time will be determined before the benefits of the plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a plan, two plans will be treated as one if You were eligible by the second within 24 hours after the first ended. The start of a new plan does not include:

- a change in the amount or scope of a plan's benefits;
- a change in the entity that pays, provides or administers the plan's benefits; or
- a change from one type of plan to another (such as from a single-employer plan to that of a multiple employer plan).

Your length of time covered by a plan is measured from Your first date of coverage with that plan. If that date is not readily available for a group plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the plans

shall share equally in the Allowable Expenses.

Each of the plans by which You are covered, and each of the benefits within the plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits in this Policy as if no Other Plan exists.

Secondary Health Plan Benefits
If, in accordance with the order of benefit determination, one or more Other Plans are primary to this coverage, the benefits in this Policy will be calculated as follows:

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will compare the Allowable Expense in this Policy for that service to the Allowable Expense for it with the Other Plan(s) by which You are covered. We will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved plans; or
- the benefits that We would have paid for the service if this coverage were the Primary Plan.

Deductibles, Coinsurance and/or Copayments, if any, in this Policy will be used in the calculation of the benefits that We would have paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. Our payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved plans and We will credit toward any Deductible in this Policy any amount that would have been credited to the Deductible if this coverage had been the only plan.

If this coverage is the Secondary Health Plan according to the order of benefit determination and any Other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Policy, We will pay benefits first, but the amount paid will be calculated as if this coverage is a Secondary Health Plan. If the Other Plan(s) do not provide Us with the information necessary for Us to determine Our appropriate secondary benefits payment within a reasonable time after Our request, We shall assume their benefits are identical to Ours and pay benefits accordingly, subject to adjustment upon receipt of the information requested from the Other Plan(s) within two years of Our payment.

Nothing contained in this Coordination of Benefits provision requires Us to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information
Certain facts are needed to apply coordination of benefits provisions. We have the right to decide which facts We need. We may get needed facts from, or give them to, any

other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to Us any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by Us will be a condition precedent to Our obligation to provide benefits in this Policy.

Facility of Payment
Any payment made by any Other Plan(s) may include an amount that should have been paid by this coverage. If so, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If We provide benefits to or on behalf of You in excess of the amount that would have been payable in this Policy by reason of Your coverage with any Other Plan(s), We will be entitled to recover from You, Your assignee or beneficiary, or from the Other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

NOTE: For Pediatric Vision benefits, We have delegated certain activities, including appeals, to VSP, though We retain ultimate responsibility over these activities. For the purpose of appeals for Pediatric Vision benefits, references to "We", "Us" and "Our" in this Appeal Process Section refer to VSP.

A verbal request can be made by calling VSP. A written request can be made by:

- completing the form available on **www.vsp.com**; or
- mailing it to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

If You believe a policy, action or decision of Ours is incorrect, contact Our Customer Service department.

If You have concerns regarding a decision, action or statement by Your Provider, We encourage You to discuss these concerns with the Provider. If You remain dissatisfied after discussing Your concern with Your Provider, You may contact Our Customer Service department for assistance.

Our Grievance process is designed to help You resolve Your complaint or concern and to allow You to appeal an Adverse Benefit Determination. We offer one internal level of appeal of Our Adverse Benefit Determinations. We also offer an external appeal with an Independent Review Organization (IRO) for some of Our Adverse Benefit Determinations if You remain dissatisfied with Our Internal Appeal decision. See External Appeal – IRO later in this section for more information.

An Internal Appeal, including an internal expedited appeal, must be pursued within 180 days of Your receipt of Our Adverse Benefit Determination. If You don't act within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum.

Internal appeals, including internal expedited appeals, are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. You or Your Representative may submit written materials supporting Your appeal, including written testimony on Your behalf. For Post-Service appeals, a written notice of the decision will be sent within 30 days of receipt of the appeal. For appeals involving a Pre-Service prior authorization of a procedure, We will send a written notice of the decision within 30 days of receipt of the appeal.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular appeal process, You or Your Provider may specifically request an expedited appeal. See Expedited Appeals later in this section for more information.

You are entitled to receive continued coverage of the disputed item or service pending the conclusion of the Internal Appeal process. However, You will be responsible for any

amounts We pay for the item or service during this time should You not prevail.

You may contact Us either in writing or verbally with a Grievance or to request an appeal. For pediatric vision, a verbal request can be made by calling VSP. A written request can be made by:

- completing the form available on **www.vsp.com**; or
- mailing it to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, a verbal request can be made by calling Customer Service. A written request can be made by:

- completing the form available on **regence.com**;
- submitting it in an e-mail to MemberAppeals@regence.com;
- submitting it via fax to 1 (888) 496-1542; or
- mailing it to Us at: Attn: Member Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 1408, Lewiston, ID 83501.

We will acknowledge receipt of a Grievance or an appeal within seven days of receiving it.

An Adverse Benefit Determination may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error the correction of which would result in overturning the Adverse Benefit Determination.

EXTERNAL APPEAL – IRO

You have the right to an external review by an IRO. An appeal to an IRO is available only after You have exhausted the Internal Appeal process, unless:

- we have mutually agreed to waive the exhaustion requirement;
- We failed to strictly comply with state and federal requirements for Internal Appeals; or
- You request expedited external appeal at the same time You request expedited Internal Appeal.

You must request an external appeal, including an external expedited appeal within 180 days of Your receipt of Our Internal Appeal decision (or sooner if the Internal Appeal process was waived). We coordinate external appeals, but the decision is made by an IRO at no cost to You. **We are bound by the decision of the IRO and may be penalized by the Oregon Division of Financial Regulation if We fail to comply with the IRO's decision. You have the right to sue Us if the decision of the IRO is not implemented.**

The issue being submitted to the IRO for external review must be a dispute over an Adverse Benefit Determination We have made concerning whether a course or plan of treatment is:

- Medically Necessary;
- experimental or Investigational;

- part of an active course of treatment for purposes of continuity of care;
- delivered in an appropriate health care setting at the appropriate level of care; or
- whether an exception to Our Drug List should be granted.

External review can be initiated through either written or verbal request. For pediatric vision, a verbal request can be made by calling VSP. A written request can be made by:

- completing the form available on **www.vsp.com**; or
- mailing it to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, a verbal request can be made by calling Customer Service. A written request can be made by:

- completing the form available on **regence.com**;
- submitting it in an e-mail to ExternalAppeals@regence.com;
- submitting it via fax to 1 (888) 309-8720; or
- mailing it to Us at: Attn: Level 2/3 Member Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 1408, Lewiston, ID 83501.

You may also initiate an external appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

When We notify You of Our Internal Appeal decision, We will send You instructions on how to request external review and **may include a waiver which is a HIPAA release form that allows Us to provide Your medical records to the IRO to review Your request**. We must notify the Oregon Division of Financial Regulation of Your request by the second business day after We receive it even if You have not provided all the documents required.

The Oregon Division of Financial Regulation will select an IRO and notify You of the IRO selection. You may submit additional information to the IRO within five business days after You receive notice of the IRO's appointment. We will provide the IRO with specific documentation regarding Our Adverse Benefit Determination and the signed waiver granting access to Your medical records within five business days of receiving the IRO selection. The IRO will make its decision within 30 days after You apply for external review. The IRO will send You a written notice of its decision within five days of the decision. If the IRO decides to reverse the original determination, then, upon receipt of the IRO's notice of this decision, We will provide coverage or payment of the claim. Choosing an external appeal as the final level to determine an appeal will be binding, except to the extent other remedies are available under state or federal law.

If You want more information regarding IRO review, contact Our Customer Service department. You can also contact the Oregon Division of Financial Regulation by:

- calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site:

https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal.

EXPEDITED APPEALS
An expedited appeal is available in clinically urgent situations if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Internal Expedited Appeal
Internal expedited appeals can be initiated through either written or verbal request. For pediatric vision, a verbal request can be made by calling VSP. A written request can be made by:

- completing the form available on **www.vsp.com**; or
- mailing it to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, a verbal request can be made by calling Customer Service. A written request can be made by:

- completing the form available on **regence.com**;
- submitting it in an e-mail to MemberAppeals@regence.com;
- submitting it via fax to 1 (888) 496-1542; or
- mailing it to Us at: Attn: Member Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 1408, Lewiston, ID 83501.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but not later than 72 hours after receipt of the expedited appeal. This will be followed by written notification within three days of the verbal notice.

External Expedited Appeal – IRO
If You disagree with the decision made in the internal expedited appeal, You may

request an external expedited appeal to an IRO if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

The issues an IRO will consider are the same as described in the External Appeal – IRO Section. You may request an external expedited review at the same time You request an internal expedited appeal from Us.

External expedited appeals can be initiated through either written or verbal request. For pediatric vision, a verbal request can be made by calling VSP. A written request can be made by:

- completing the form available on **www.vsp.com**; or
- mailing it to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, a verbal request can be made by calling Customer Service. A written request can be made by:

- completing the form available on **regence.com**;
- submitting it in an e-mail to ExternalAppeals@regence.com;
- submitting it via fax to 1 (888) 309-8720; or
- mailing it to Us at: Attn: Level 2/3 Member Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 1408, Lewiston, ID 83501.

We must notify the Oregon Division of Financial Regulation of Your request by the second business day after We receive it.

You may also request an external expedited appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

We coordinate external expedited appeals, but the decision is made by an IRO at no cost to You. **We may request a waiver which is a HIPAA release form that grants the IRO access to medical records that may be required to be reviewed for the purpose of reaching a decision on the expedited appeal**. We will provide the IRO with the expedited appeal documentation. You may submit additional information to the IRO no later than 24 hours after the appointment of the IRO. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of Your request. The IRO decision is binding, except to the extent other remedies are available under state or federal law.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal.

INFORMATION
For pediatric vision benefits, if You have any questions about the appeal process, contact VSP or write to the following address: Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, if You have any questions about the appeal process, contact Customer Service or write to the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884.

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by:

- calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

You also are entitled to receive from Us, upon request and free of charge, reasonable access to and copies of all documents, records, and other information considered, relied upon, or generated in, or otherwise relevant to, an Adverse Benefit Determination.

DEFINITIONS
The following definitions apply to this Appeal Process Section:

Adverse Benefit Determination means Our denial, reduction or termination of a health care item or service, or Our failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on Our:

- denial of eligibility for or termination of enrollment;
- rescission or cancellation of a policy;
- imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- determination that a health care item or service is experimental, Investigational or not Medically Necessary, effective or appropriate; or
- determination that a course or plan of treatment that You are undergoing is an active course of treatment for purposes of continuity of care.

Grievance means a submission by You or Your authorized Representative that either is a written or oral request for Internal Appeal or external review (including expedited appeal or review), or is a written complaint regarding:

- health care service availability, delivery, or quality;
- payment, handling, or reimbursement of a health care service claim; or

- contractual matters between You and Us.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for external appeals and external expedited appeals and that is not controlled by Us.

Internal Appeal means a review by Us of an Adverse Benefit Determination made by Us.

Post-Service means any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which We must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the Grievance. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Grievance. No authorization is required from the parent(s) or legal guardian of an Insured who is an unmarried and dependent child and is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for a complaint that becomes an appeal or between levels of appeal). If no authorization exists and is not received in the course of the Grievance, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Eligibility and Enrollment

Matters concerning eligibility, such as application for coverage, residency requirement, dependent enrollment, qualifying events that allow for a special enrollment period and coverage effective dates are determined by the Oregon Health Insurance Marketplace (Marketplace). For additional information about eligibility and enrollment, contact the Marketplace.

OPEN ENROLLMENT PERIOD

Open enrollment is a specific period of time each Calendar Year during which enrollment under this Policy is open to all who qualify. The dates of the open enrollment period are established by the Marketplace. Refer to the Marketplace for the most current open enrollment dates.

DOCUMENTATION OF DEPENDENT ELIGIBILITY

You must promptly provide (or coordinate) to the Marketplace any necessary and appropriate information to determine the eligibility of a dependent. Such information will be required before a person can be enrolled as a dependent in this Policy.

When Coverage Ends

Please note that matters concerning coverage termination dates are determined by the Marketplace. Therefore, some, though not all, information concerning these matters is included in this Policy. For additional information, contact the Marketplace.

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents.

No person will have a right to receive any benefits after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Policy for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Policy was in effect.

GUARANTEED RENEWABILITY AND POLICY TERMINATION
This Policy is guaranteed renewable, at the option of the Policyholder, upon payment of the monthly premium when due or within the requirements established by the Marketplace, including any provisions pertaining to a grace period.

In the event We eliminate the coverage described in this Policy for the Policyholder and all Enrolled Dependents, We will provide 90-days written notice to all Insureds covered by this Policy. We will make available to the Policyholder, on a guaranteed issue basis and without regard to the health status of any Insured covered through it, the option to purchase one or more individual coverage(s) being offered by Us for which the Policyholder qualifies.

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Oregon Division of Financial Regulation, Policyholder and all Enrolled Dependents.

If this Policy is terminated or not renewed by the Policyholder or Us, coverage ends for You and Your Enrolled Dependents on the date determined by the Marketplace. If We terminate this Policy for any reason, We will provide You written notice at least 30 days' prior to the last day of coverage.

MILITARY SERVICE
An Insured whose coverage under this Policy terminates due to entrance into military service may request, in writing, a refund of any prepaid premium on a pro rata basis for any time in which this coverage overlaps such military service.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the date determined by the Marketplace.

Nonpayment of Premium
Payment of Your initial premium is required for coverage to begin. If Your initial premium payment is not received, then coverage for You and Your Enrolled

Dependents is considered as never effective. If You fail to timely pay Your monthly premium as required, coverage will end for You and all Enrolled Dependents.

Termination by You
You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving written notice to the Marketplace, which will provide Us with the notice of termination. Upon receiving a request for termination, We will cancel this Policy on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. We will refund You any premium received on an Insured's behalf for any period of ineligibility, providing that no benefits were paid during the interim.

GRACE PERIOD
A grace period of 30 days, or of 90 days for Insureds enrolling through the Marketplace whose premium is subsidized by the federal government's payment of a portion of Your premium as an advance of the premium tax credit, will be granted for the payment of the regular monthly premium after payment of the first month's premium. During this grace period this Policy shall not be terminated.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible due to events such as divorce, annulment or termination of domestic partnership, death of the Policyholder or loss of dependent status as determined by the Marketplace, their coverage will end on the date assigned by the Marketplace.

OTHER CAUSES OF TERMINATION
Insureds may be terminated for any of the following reasons as explained below.

Fraudulent Use of Benefits
If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under this Policy will terminate for that Insured.

Fraud or Misrepresentation in Application
We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding an Insured, We may take any action allowed by law or Policy, including denial of benefits or termination of coverage and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

If We rescind Your coverage, other than for failure to pay premium, We will provide You with at least 30 days advance written notice prior to rescinding coverage.

MEDICARE SUPPLEMENT
When eligibility under this Policy terminates, You may be eligible for coverage under a Medicare supplement plan through Us as described here.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our

Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from this Policy. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from this Policy.

General Provisions and Legal Notices

This section explains various general provisions and legal notices regarding Your benefits under this coverage.

CHOICE OF FORUM
Any legal action arising out of this Policy must be filed in a court in the state of Oregon.

GOVERNING LAW AND BENEFIT ADMINISTRATION
This Policy will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Oregon without regard to its conflict of law rules. We are an insurance company that provides insurance to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Insured rights per this benefit plan that include the right to appeal, review by an IRO and civil action.

LIMITATIONS ON LIABILITY
You have the exclusive right to choose a health care Provider. We are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents.

Under state law, Providers contracting with a health care service contractor like Us to provide services to its Insureds agree to look only to the health care service contractor for payment of services that are covered by this Policy and may not bill You if the health care service contractor fails to pay the Provider for whatever reason. The Provider may bill You for applicable Deductible, Copayment and/or Coinsurance and for non-Covered Services, except as may be restricted in the Provider contract.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Policy by reason of epidemic, disaster or other cause or condition beyond Our control.

MODIFICATION OF POLICY
We shall have the right to modify or amend this Policy from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to the Policyholder. The modification must be uniform within the product line and at the time of renewal.

However, when a change in this Policy is beyond Our control (e.g., legislative or regulatory changes take place), We may modify or amend this Policy on a date other than the renewal date, including changing the premium rates, as of the date of the change in this Policy. We will give You prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify You in writing of a change of premium rates within 30 days after the later of the Effective Date or the date of Our implementation of a statute or regulation.

Provided We give notice of a change in premium rates within the above period, the

change in premium rates shall be effective from the date for which the change in this Policy is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Policyholder's acceptance of a premium rate change.

Changes can be made only through a modified Policy, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Policy.

NO WAIVER
The failure or refusal of either party to demand strict performance of this Policy or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of this Policy will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NONASSIGNMENT
Only You are entitled to benefits under this Policy. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on Us. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

NOTICES
Any notice to Insureds required in this Policy will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be mailed to Our Customer Service address. However, notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS
Premiums are to be paid to Us by the Policyholder on or before the premium due date. Failure by the Policyholder to make timely payment of premiums may result in Our terminating this Policy on the last day of the monthly period through which premiums are paid or such later date as provided by applicable law.

Premium Payments
Except as required by law, We will not accept payments of premium or other cost-sharing obligations on behalf of an Insured from a Hospital, Hospital system, health-affiliated aid program, healthcare Provider or other individual or entity that has received or may receive a financial benefit related to the Insured's choice of health care. As required by the Centers for Medicare and Medicaid Services (CMS), We will accept

premium and cost-sharing payments made on behalf of Insureds by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

You, on behalf of Yourself and any Enrolled Dependents, expressly acknowledge Your understanding that this Policy constitutes an agreement solely with Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Us to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington, and that We are not contracting as the agent of the Association. You, on behalf of Yourself and any Enrolled Dependents, further acknowledge and agree that You have not entered into this Policy based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon will be held accountable or liable to You for any of Our obligations to You created under this Policy. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of this Policy.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an application will be considered representations and not warranties. No statement made for obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by Us may include, but is not limited to:

- billing statements;
- claim records;

- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

We are required by law to protect Your personal health information and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting Our Web site or contacting Customer Service.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Contact Customer Service to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for Us to receive information related to these health conditions.

TAX TREATMENT
We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

TIME LIMIT ON CERTAIN DEFENSES
After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, You made in the application will be used to void this Policy or to deny a claim for health care services commencing after the expiration of the two-year period.

WHEN BENEFITS ARE AVAILABLE
In order for health expenses to be covered, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions of this Policy;
- the person has applied and has been accepted for coverage by Us; and
- premium for the person for the current month has been paid by the Policyholder on a timely basis.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS
If You are receiving benefits in connection with a Mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, We will provide coverage (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the Mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;

- prosthesis and treatment of physical complications of all stages of Mastectomy, including lymphedemas; and
- inpatient care related to the Mastectomy and post-Mastectomy services.

We will provide a single determination of prior authorization for all services related to a covered Mastectomy that are part of Your course or plan of treatment.

Definitions

The following are definitions of important terms, other terms are defined where they are first used.

Affiliate means a company with which We have a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services. However, with regard to Providers who have entered Risk-Sharing Arrangements with Us for this plan, the Allowed Amount is the amount they have agreed to accept in initial payment, without regard to any subsequent reward to which they may become entitled or refund or payment for which they may become liable under the Risk-Sharing Arrangement.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount We have determined to be Reasonable Charges for Covered Services.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, We may substitute another payment basis.

Charges in excess of the Allowed Amount are not considered Reasonable Charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact Customer Service.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

Ambulatory Surgical Center does not mean:

- individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a Physician's or dentist's office using local anesthesia or conscious sedation; or
- a portion of a licensed Hospital designated for outpatient surgical treatment.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Insured's Effective Date.

Center of Excellence means a Provider organization certified to deliver a gene therapy (or therapies) that meets or exceeds a set of clinical service and quality standards (including available clinical services, patient selection criteria, and outcome reporting),

maintains a set of clinical protocols and certifications required for gene therapy delivery, and maintains or exceeds a foundation of rigorous and sustainable cost controls.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefit sections in this Policy.

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily to separate the patient from others or prevent self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Insured's home.

Effective Date means the first day of coverage for You and/or Your dependents, following Our receipt and acceptance of the application.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Insured's health, or with respect to a pregnant Insured, the health of the unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- a behavioral health crisis. "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a Hospital to prevent a serious deterioration in the individual's mental or physical health.

Emergency Medical Condition also includes a condition with respect to a pregnant Insured who is having contractions, for which there is inadequate time for a safe transfer to another Hospital before delivery or for which transfer may pose a threat to the health or safety of the Insured or unborn child.

Enrolled Dependent means a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage under the terms of this Policy by Us.

Family means a Policyholder and any Enrolled Dependents.

Health Benefit Plan means any Hospital-medical-surgical expenses policy or certificate issued by insurers including health care service contractors and health maintenance organizations.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital per this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Illness does not include any state of mental health or mental disorder which is otherwise defined in the Mental Health or Substance Use Disorder Services benefit.

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean Injury to teeth due to chewing and does not include any condition related to pregnancy.

In-Network means a contracted Provider with Us or one of Our Affiliates in Your Provider network who provides services and supplies to Insureds in accordance with the

provisions of this coverage. Your network is Legacy LHP. In-Network also means a Provider outside the area that We or one of Our Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. Refer to the Out-of-Area Services Section for additional details. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Insured means any person who satisfies the eligibility qualifications and is enrolled for coverage under this Policy.

Investigational means a Health Intervention that fails to meet any of the following criteria:

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

In applying the above criteria, We will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention.

Lifetime means the entire length of time an Insured is covered under this Policy (which may include more than one coverage) with Us.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;

- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

Oregon Health Insurance Marketplace or Marketplace means an online health insurance marketplace implemented under the Affordable Care Act where consumers can, among other things, purchase health insurance.

Out-of-Network means a Provider that is not In-Network. Out-of-Network Providers include those Providers who have contracted with Us but are outside Your network. Services provided by Out-of-Network Providers are not covered, except as specified in the Medical Benefits Section. For Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serve.

Physician means an individual who is duly licensed to practice medicine and/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon. Physician also includes a podiatrist practicing within the scope of a license issued under ORS 677.805 to 677.840.

Policy is the description of the benefits for this coverage. This Policy is also the agreement between You and Us for a Health Benefit Plan.

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists who do not meet the definition of Physician;
- Physician's assistants;
- psychologists;
- licensed clinical social workers;
- certified nurse Practitioners;
- registered physical, occupational, speech or audiological therapists;
- registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients);
- dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist); and
- other health care professionals practicing within the scope of their respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed and is licensed in:

- general practice;
- family practice;
- internal medicine;

- pediatrics;
- geriatrics;
- obstetrics/gynecology (Ob/Gyn);
- preventive medicine;
- adult medicine;
- women's health care; or
- naturopathy.

Primary Physician or Practitioner also means any Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

Provider means:

- a Hospital;
- a Skilled Nursing Facility;
- an Ambulatory Surgical Center;
- a Physician;
- a Practitioner; or
- other individual or organization which is duly licensed to provide medical or surgical services.

Reasonable Charges means an amount determined based on one of the following, as determined by Us:

- 125% of the fee paid by Medicare for the same services or supplies;
- 90% of the amount that the same or similar category of In-Network Providers have contractually agreed to accept as payment in full for the same or similar services or supplies in the same or similar service area; or
- 40% of the Out-of-Network Provider's billed charges.

Under no circumstances will any fee exceeding 300% of the fee paid by Medicare for the same services or supplies be considered Reasonable Charges.

Regardless of anything in this Policy to the contrary, if We are required by applicable law to base payment on another amount, that amount will be Reasonable Charges.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center or facility;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

Risk-Sharing Arrangement means a contractual arrangement with an In-Network Provider under which the Provider assumes financial risk related to aggregate quality,

utilization, and/or similar measures of the Provider's (and/or that Provider's and associated Providers') services. Under a Risk-Sharing Arrangement, a Provider may become entitled to payments from Us separate from Allowed Amounts already paid or may become liable to make payments or refunds to Us. Payments under a Risk-Sharing Arrangement, however, are based on aggregate performance data, are not specific to any Insured, and will not change the Allowed Amount or result in adjustment to Your cost-sharing. That is, a Risk-Sharing Arrangement payment to an In-Network Provider will not require an adjustment for You to pay additional cost-sharing corresponding to that additional payment and a Risk-Sharing Arrangement payment or refund from a Provider will not result in an adjustment reducing Your cost-sharing.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Specialist means a Physician, Practitioner or urgent care facility that does not otherwise meet the definition of a Primary Physician or Practitioner.

Upfront Benefit means those Covered Services designated as "Upfront" which are usually accessible to the Insured without first having to satisfy any Deductible amount. There may not be any Coinsurance amount required for an Upfront Benefit. However, a Copayment may apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum has been reached, additional coverage is available subject to any Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit to determine coverage.

Appendix: Value-Added Services

Your Regence coverage includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS POLICY.**

For additional information regarding any of these value-added services, visit Our Web site or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

INDIVIDUAL ASSISTANCE PROGRAM (IAP)
An IAP is short-term, confidential counseling at no out-of-pocket expense. This IAP is available to the following "clients":

- the Policyholder;
- the Policyholder's legal dependents (whether or not they are enrolled in this coverage or living in the Policyholder's home); and
- anyone living in the Policyholder's home (whether or not they are enrolled in this coverage or related to the Policyholder).

The following services are provided as part of this IAP:

- **24-Hour Crisis Counseling**
  The IAP hotline number is answered by professional counselors 24 hours a day, 7 days a week. Clients can call the hotline directly at 1 (866) 750-1327.

- **Short-Term Counseling**
  An "incident" means a separate event or events occurring in the client's life. Four counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of four counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.

- **Referral**
  If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this IAP. Services not included in this IAP will be subject to the benefits in this Policy.

- **Follow-up**
  When necessary and appropriate, the counselor may follow up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if this IAP service can be of further assistance.

KIDNEY HEALTH MANAGEMENT
If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and

unknown as well as end stage renal disease (ESRD). The program defers progression of CKD, reduces the cost of care by avoiding adverse events such as emergency room visits, hospitalizations and post-acute care.

NURSE ADVICE
You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

PREGNANCY PROGRAM
Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit Our Web site right away to get started.

REGENCE EMPOWER
Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to a total of $100 in gift cards for completion of well-being activities such as an online health risk assessment, health screening(s) and wellness examination(s);
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

Disclosure Statement Patient Protection Act

In accordance with Oregon law (Senate Bill 21, known as the Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform You about the benefits and policies of this health insurance plan.

WHAT ARE MY RIGHTS AND RESPONSIBILITIES AS AN INSURED OF REGENCE BLUECROSS BLUESHIELD OF OREGON?

No one can deny You the right to make Your own choices. As an Insured, You have the right to:

- be treated with dignity and respect;
- impartial access to treatment and services without regard to race, religion, gender, national origin or disability;
- know the name of the Physicians, nurses or other health care professionals who are treating You;
- medical care necessary to correctly diagnose and treat any covered Illness or Injury;
- have Providers tell You about the diagnosis, the treatment ordered, the prognosis of the condition and instructions required for follow-up care;
- know why various tests, procedures or treatments are done, who the persons are who give them and any risks You need to be aware of;
- refuse to sign a consent form if You do not clearly understand its purpose, cross out any part of the form You don't want applied to care or have a change of mind about treatment You previously approved;
- refuse treatment and be told what medical consequences might result from Your refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain Your rights to make health care decisions, in advance, if You become unable to make them);
- expect privacy about care and confidentiality in all communications and in Your medical records;
- expect clear explanations about benefits and exclusions;
- contact Our Customer Service department and ask questions or present complaints; and
- be informed of the right to appeal an action or denial and the related process.

You have a responsibility to:

- tell the Provider You are covered by Regence BlueCross BlueShield of Oregon and show Your identification card when requesting health care services;
- be on time for appointments and to call immediately if there is a need to cancel an appointment or if You will be late. You are responsible for any charges the Provider makes for "no shows" or late cancellations;
- provide complete health information to the Provider to help accurately diagnose and treat Your condition;
- follow instructions given by those providing health care to You;
- review this health care benefits Policy to make sure services are covered by this Policy;

- make sure services are prior authorized when required by this Policy before receiving medical care;
- contact Our Customer Service department if You believe adequate care is not being received;
- read and understand all materials about Your health benefits and make sure Family members that are covered under this Policy also understand them;
- give an identification card to Your enrolled Family members to show at the time of service; and
- pay any required Copayments at the time of service.

HOW DO I ACCESS CARE IN THE EVENT OF AN EMERGENCY?
If You experience an emergency situation, You should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether Your condition requires emergency treatment, You can always call the Provider for advice. The Provider is able to assist You in coordinating medical care and is an excellent resource to direct You to the appropriate care since they are familiar with Your medical history.

HOW WILL I KNOW IF MY BENEFITS CHANGE OR ARE TERMINATED?
If You have an individual Policy, We will send You notification of any benefit changes through the mail. In addition, You can always contact Our Customer Service Department and ask a representative about Your current benefits.

WHAT HAPPENS IF I AM RECEIVING CARE AND MY DOCTOR IS NO LONGER A CONTRACTING PROVIDER?
When a Physician's or Practitioner's (herein Provider) contract ends with Us for any reason, We will give notice to those Insureds that We know, or should reasonably know, are under the care of the Provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than ten days after the Provider's termination date or ten days after the date We learn the identity of an affected Insured, whichever is later. The exception to Our sending the notice is when the Provider is part of a group of Providers and We have agreed to allow the Provider group to provide continuity of care notification to Insureds.

When Continuity Of Care Applies. If You are undergoing an active course of treatment by an In-Network Provider and benefits for that Provider would be denied (or paid at a level below the benefit for an Out-of-Network Provider) if the Provider's contract with Us is terminated or the Provider is no longer participating with Us, We will continue to pay benefits for services and supplies provided by the Provider as long as:

- You and the Provider agree that continuity of care is desirable and You request continuity of care from Us;
- the care is Medically Necessary and otherwise covered under this Policy;
- You remain eligible for benefits and enrolled under this Policy; and
- this Policy has not terminated.

Continuity of care does not apply if the contractual relationship between the Provider and Us ends in accordance with quality of care provisions of the contract between the

Provider and Us, or because the Provider:

- retires;
- dies;
- no longer holds an active license;
- has relocated outside of Our service area;
- has gone on sabbatical; or
- is prevented from continuing to care for patients because of other circumstances.

How Long Continuity Of Care Lasts. Except as follows for pregnancy care, We will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling You to continuity of care is completed; or
- the 120th day after notification of continuity of care.

If You become eligible for continuity of care after the second trimester of pregnancy, We will provide continuity of care for that pregnancy until the earlier of the following dates:

- the 45th day after the birth;
- the day following the date on which the active course of treatment entitling You to continuity of care is completed; or
- the 120th day after notification of continuity of care.

The notification of continuity of care will be the earlier of the date We or, if applicable, the Provider group notifies You of the right to continuity of care, or the date We receive or approve the request for continuity of care.

COMPLAINT AND APPEALS: IF I AM NOT SATISFIED WITH MY HEALTH PLAN OR PROVIDER WHAT CAN I DO TO FILE A COMPLAINT OR GET OUTSIDE ASSISTANCE?

To voice a complaint with Us, simply follow the process outlined in the Appeal Process Section of this Policy. This includes if applicable, information about filing an appeal through an IRO without charge to You.

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by:

- calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

HOW CAN I PARTICIPATE IN THE DEVELOPMENT OF YOUR CORPORATE POLICIES AND PRACTICES?

Your feedback is very important to Us. If You have suggestions for improvements about coverage or Our services, We would like to hear from You.

We have formed several advisory committees to allow participation in the development

of corporate policies and to provide feedback:

- the Member Advisory Committee for Insureds;
- the Marketing Advisory Panel for employers; and
- the Provider Advisory Committee for health care professionals.

If You would like to become a member of the Member Advisory Committee, send Your name, identification number, address and phone number to the vice president of Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon, Attn: Vice President, Customer Service, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884 or send Your comments to Us through Our Web site.

Please note that the size of the committees may not allow Us to include all those who indicate an interest in participating.

WHAT ARE YOUR PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?

Prior authorization is the process We use to determine the benefits, eligibility and Medical Necessity of a service before it is provided. Contact Our Customer Service department at the phone number on the back of Your identification card or ask Your Provider for a list of services that need to be prior authorized. Many types of treatment may be available for certain conditions; the prior authorization process helps the Provider work together with You, other Providers and Us to determine the treatment that best meets Your medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for You. Prior authorization is Your assurance that medical services won't be denied because they are not Medically Necessary.

Utilization management is a process in which We examine services an Insured receives to ensure that they are Medically Necessary and appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of Medically Necessary in the Definitions Section.

Let Us know if You would like a written summary of information that We may consider in Our utilization management of a particular condition or disease. Simply call the Customer Service phone number on the back of Your identification card or log onto Our Web site.

HOW ARE IMPORTANT DOCUMENTS (SUCH AS MY MEDICAL RECORDS) KEPT CONFIDENTIAL?

We have a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs have access to an Insured's personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing Your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from the Insured or their

representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance or peer review.

MY NEIGHBOR HAS A QUESTION ABOUT THEIR POLICY WITH YOU AND DOESN'T SPEAK ENGLISH VERY WELL. CAN YOU HELP?

Yes. Simply have Your neighbor call Our Customer Service department at the number on their identification card. One of Our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

WHAT ADDITIONAL INFORMATION CAN I GET FROM YOU UPON REQUEST?

The following documents are available by calling a Customer Service representative:

- Rules related to Our Drug List, including information on whether a particular medication is included or excluded from the Drug List.
- Provisions for referrals for specialty care, behavioral health services and Hospital services and how Insureds may obtain the care or services.
- Our annual report on complaints and appeals.
- A description of Our Risk-Sharing Arrangements with Physicians and other Providers consistent with risk-sharing information required by the Health Care Financing Administration. A description of Our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network Providers and how to obtain the names, qualifications and titles of the Providers responsible for an Insured's care.
- Information about Our prior authorization and utilization management procedures.

WHAT OTHER SOURCE CAN I TURN TO FOR MORE INFORMATION ABOUT YOUR COMPANY?

The following information regarding the Health Benefit Plans of Regence BlueCross BlueShield of Oregon is available from the Oregon Division of Financial Regulation:

- The results of all publicly available accreditation surveys.
- A summary of Our health promotion and disease prevention activities.
- Samples of the written summaries delivered to Policyholders.
- An annual summary of appeals.
- An annual summary of utilization management policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, contact Our Customer Service department. You can also contact the Oregon Division of Financial Regulation by:

- calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

For more information call Us at 1 (888) 675-6570

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is an Independent Licensee of the BlueCross and
BlueShield Association